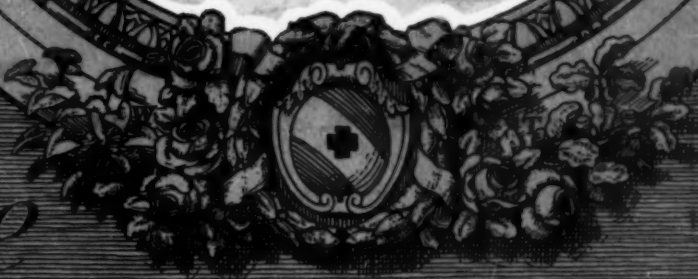


*Hospital Library*

JUL 5 - 1932



*The*  
**MODERN  
HOSPITAL**

Vol. XXXIX

JULY, 1932

No. 1

# ...IN AKRON

More than 75% of Akron's hospital beds are  
in institutions served by American Sterilizers



## AKRON CITY HOSPITAL

Mr. A. E. Hardgrove, Supt.

Good & Wagner, Architects

Completely equipped with American Sterilizers

• • •

## CHILDRENS HOSPITAL

Mr. H. H. Graef, Supt.

Good & Wagner, Architects

Completely equipped with American Sterilizers

## AMERICAN STERILIZER COMPANY

1200 Plum St., ERIE, PENNSYLVANIA

EASTERN SALES OFFICE: 200 Fifth Ave., New York City

CANADIAN AGENTS: Ingram & Bell, Ltd., Toronto, Montreal, Winnipeg, Calgary



# CONTENTS

For July, 1932

COVER PAGE—Sarah Wey Tompkins Memorial Pavilion, New Haven Hospital, New Haven, Conn.

Henry C. Pelton, Architect, New York City.

## ORIGINAL ARTICLES

Should the General Hospital Treat Mental and Contagious Cases?.....	45
F. G. Carter, M.D.	
An Experiment With Group Nursing That Augurs Success.....	49
Joseph Turner, M.D.	
How the Administrator May Solve His "Depression" Problems.....	55
Ara Davis	
Who Trusts a Trustee?.....	57
Howard S. Cullman	
How the Pathologic Laboratory Can Best Serve the State Hospital.....	59
Walter Freeman, M.D., Ph.D.	
How the Record Librarian Serves Three Masters Impartially.....	64
Grace Whiting Myers	
A Woman's Hospital Sets a New Goal in Its March of Progress.....	67
Moritz Kahn	
The Dietitian—Her Past, Present and Future.....	73
C. J. Decker	
A Laundry Plant That Was Built Practically Overnight.....	75
W. R. Chenoweth	
Making Surgery Available to the Sanatorium Patient.....	79
Edward S. Welles, M.D.	
Hurd Hall at Johns Hopkins Honors First Superintendent.....	81
Winford H. Smith, M.D.	
When Is the Charitable Hospital Liable and Why?.....	83
W. F. Schick	
Enhancing the Hospital's Service by a Photographic Unit.....	85
R. C. Buerki	
The Hospital Holds a "Clinic" Over the Incoming Patient.....	87
E. L. Place	

(Continued on page 4)

Published the first of each month by  
THE MODERN HOSPITAL PUBLISHING CO., Inc.

Charter member Audit Bureau of Circulations

919 NORTH MICHIGAN, CHICAGO—Telephone, Superior 6402  
NEW YORK OFFICE—515 Madison Avenue. Telephone, Plaza 3-6969

## SUBSCRIPTION

United States and Possessions, \$3.00. Canada and Foreign, \$4.00. Single copies (current), 35 cents. Back copies, 50c to \$1.00.

Copyright, 1932, by THE MODERN HOSPITAL PUBLISHING CO., INC. Entered as second-class matter Oct. 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879.

Printed in U. S. A.

# CONTENTS

M.H.

Sane Methods of Credits and Collections.....	88
Is Your Problem Answered Here?.....	95
Affiliate Courses and Advantages They Offer the Nurse.....	97
Minnie E. Howe, R.N.	
Recent Progress in Nutrition and How It Affects the Dietitian.....	124
Sybil L. Smith	
An Electrolytic Cell for Making Dakin's Solution.....	132
William H. Zabel	
An Atomizing Alcohol Dispenser for the Scrub-Up Room.....	136
E. P. Magee	

## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Recent Progress in Nutrition and How It Affects the Dietitian.....	124
--	-----

## PRACTICAL ADMINISTRATIVE PROBLEMS

Sane Methods of Credits and Collections.....	88
--	----

## EDITORIALS

A Word of Cheer for Lugubrious Administrators.....	92
Honesty <i>Versus</i> Politics .....	92
The Graduate Nurse Needs Our Help.....	93
Mental Patients and Mental Attitudes.....	93
July Days in the Hospital.....	94
Staff Memberships in Local Medical Organizations.....	94

## NURSING AND THE HOSPITAL

Affiliate Courses and Advantages They Offer the Nurse.....	97
--	----

NEWS OF THE MONTH.....	106
------------------------	-----

## HOSPITAL EQUIPMENT AND OPERATION

An Electrolytic Cell for Making Dakin's Solution.....	132
An Atomizing Alcohol Dispenser for the Scrub-Up Room.....	136
A Continuous Bath and How It Functions.....	138
A Rubber Tire That Stands Hard Usage.....	142
A Direct or Indirect Light Unit for Hospital Rooms.....	142
A Revolving Bed Bumper That Protects the Walls.....	144

(Continued on page 6)

Call it what you will. It is



**PROCAINE HYDROCHLORIDE**

REGARDLESS of the particular trade name under which it may be marketed, Procaine Hydrochloride is still Procaine Hydrochloride. This is the U. S. P. designation for the very useful cocaine substitute first introduced in 1905.

Procaine Hydrochloride Crystals Squibb for Spinal Anesthesia is packaged in sterile ampuls of sufficient size to allow convenient mixing with spinal fluid before injection. Directions for use are enclosed with every package.

Available in ampuls of 50, 100, 120, 150 and 200 milligrams, 10 ampuls to the package.

For further information regarding Procaine Hydrochloride Crystals Squibb and other Squibb Anesthetics, write to Anesthetic Department, E. R. Squibb & Sons, 745 Fifth Avenue, New York.

**SQUIBB ANESTHETICS**

ETHER · CHLOROFORM · PROCAINE HYDROCHLORIDE CRYSTALS



# CONTENTS

M·H

(Continued from page 4)

## MISCELLANEOUS

California's New Research Project on Mental Health.....	48
Acquainting Trustees With the Best in Hospital Practice.....	48
Should the Superintendent of Nurses Make Night Rounds?.....	54
U. S. Spends \$13,000,000 for Veterans' Hospitals.....	56
Oversupply Problem Up to Nurses Says Doctor Burgess.....	63
How the Drive Against Cancer Is Progressing.....	63
Encouraging Hospital Workers to Save for the Future.....	66
New Veterans' Hospital Will Be Built at Batavia, N. Y.....	74
Changing Trends in Out-Patient Department Work.....	78
The Fundamentals of a Hospital Record System.....	78
The Value of Dramatizing the Daily Work of the Hospital.....	80
How a Famous Mental Hospital Is Curing Paresis.....	82
Outwitting the Outwitters—An Almost Comic Opera.....	82
More Clinic Cases at Grant Hospital, Chicago.....	87
Increased Service at Reduced Cost for These Young Patients.....	91
What We Need to Know About Food (Bk. Rev.).....	130
Traveling Dental Clinic Serves Isolated Ontario Districts.....	130

INDEX TO ADVERTISERS.....	9-10
---------------------------	------

CLASSIFIED ADVERTISEMENTS (POSITIONS WANTED, POSITIONS OPEN) .....	148-158
---	---------



## Turkish Towels

that WEAR  
WEAR  
WEAR  
**WEAR!**

and that are inexpensively  
priced.

✦ ✦

*Write for samples and  
quotations now!*

✦ ✦

**JOHN W. FILLMAN CO.**

1020 Filbert Street  
PHILADELPHIA, PA.

# THE MODERN HOSPITAL

MH

THE MODERN HOSPITAL PUBLISHING CO., INC.

OTHO F. BALL, M.D., *President*

919 NORTH MICHIGAN, CHICAGO, ILLINOIS

## EDITORIAL BOARD

JOSEPH C. DOANE, M.D., *Chairman*

JOHN A. McNAMARA, *Executive Editor*

### *Planning and Construction*

S. S. GOLDWATER, M.D.  
C. W. MUNGER, M.D.

### *Equipment and Maintenance*

E. M. BLUESTONE, M.D.  
ADA BELLE MCCLEERY, R.N.

### *Mental Hospital Administration*

J. ALLEN JACKSON, M.D.  
WILLIAM A. WHITE, M.D.

### *Public Relations*

ASA S. BACON  
R. C. BUERKI, M.D.

### *Administration*

A. C. BACHMEYER, M.D.  
LEWIS A. SEXTON, M.D.

### *Professional Relations*

M. T. MACEACHERN, M.D.  
WILLARD C. RAPPLEYE, M.D.

### *Public Health*

W. S. RANKIN, M.D.  
COL. HUGH SCOTT

### *Out-Patient Service*

MICHAEL M. DAVIS, PH.D.  
A. K. HAYWOOD, M.D.

## EDITORIAL CONSULTANTS

B. W. BLACK, M.D.  
Highland Hospital, Oakland, Calif.

ANNA E. BOLLER  
Rush Medical College, Chicago

L. H. BURLINGHAM, M.D.  
Barnes Hospital, St. Louis

IDA M. CANNON  
Massachusetts General Hospital, Boston

FRED G. CARTER, M.D.  
Ancker Hospital, St. Paul, Minn.

CAROLYN E. DAVIS, R.N.  
Good Samaritan Hospital, Portland, Ore.

CAPT. ARTHUR W. DUNBAR  
Medical Corps, U. S. Navy, Washington, D. C.

H. L. EASON, C.B., C.M.G., M.D., M.S.  
Guy's Hospital, London, England

LULU G. GRAVES  
7 East Fifty-Fourth Street, New York City

REV. MAURICE F. GRIFFIN  
Cleveland

JOHN R. HOWARD, JR.  
New York Hospital-Cornell Medical College  
Association, New York City

T. B. KIDNER  
175 Fifth Avenue, New York City

M. HELENA McMILLAN, R.N.  
Presbyterian Hospital, Chicago

D. L. RICHARDSON, M.D.  
Providence City Hospital, Providence, R. I.

RALPH B. SEEM, M.D.  
Stanford University Hospitals, San Francisco

GEORGE D. SHEATS  
Baptist Memorial Hospital,  
Memphis, Tenn.

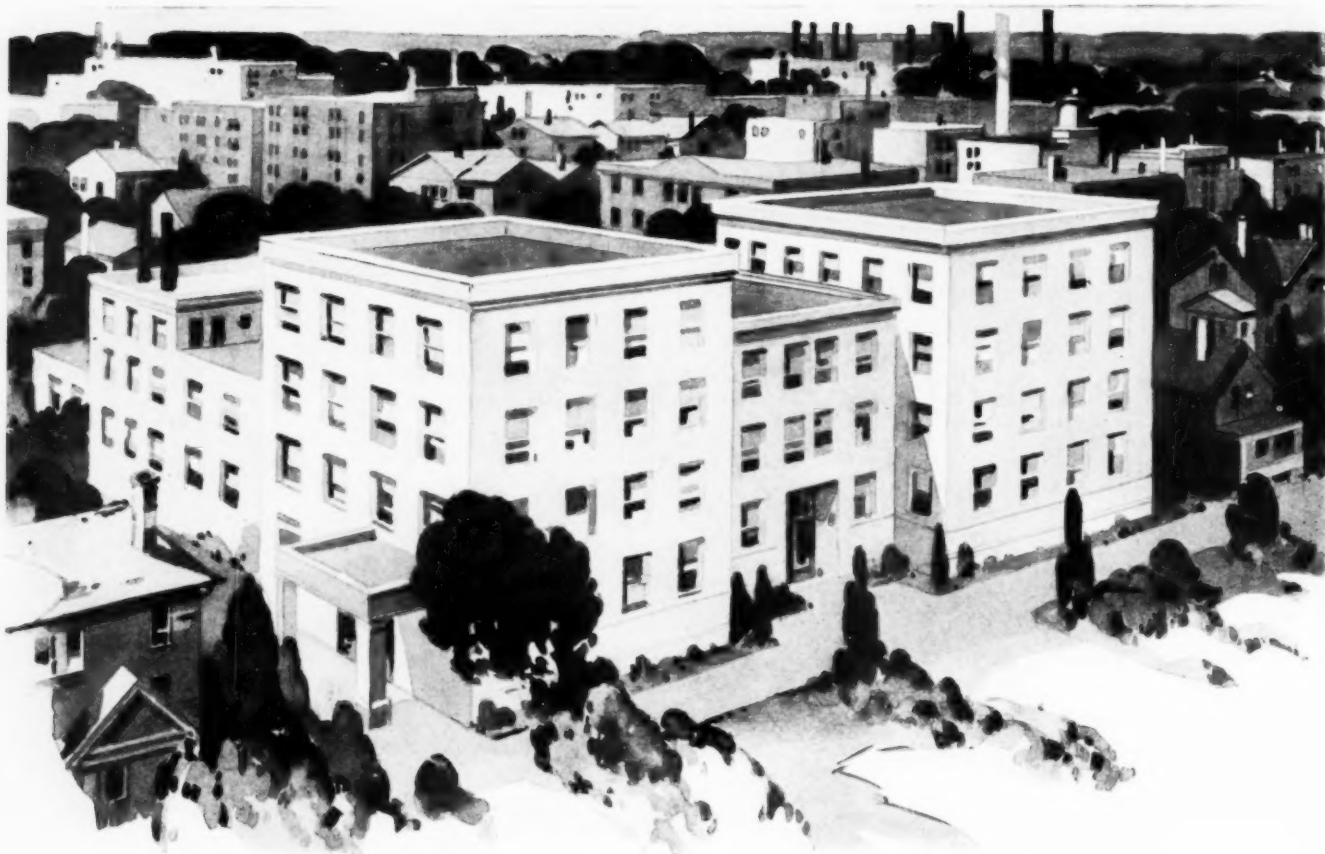
DONALD C. SMELZER, M.D.  
Graduate Hospital of the University  
of Pennsylvania, Philadelphia

HERMAN SMITH, M.D.  
Michael Reese Hospital, Chicago

ROY WATSON  
Kahler Hospital, Rochester, Minn.

JOSEPH J. WEBER  
Vassar Brothers Hospital, Poughkeepsie, N. Y.

LUCIUS R. WILSON, M.D.  
John Sealy Hospital, Galveston, Tex.



## ISOLATE the Hospital from External FIRE DANGERS

Fires originating in adjacent buildings are a constant source of danger to the hospital and its patients. Yet the hospital can be almost completely isolated from exposure fires, frequently at very small expense.

Without cost you may have a complete inspection of your hospital property by an experienced fire prevention engineer. His suggestions and recommendations will enable you to overcome hazards that may have been overlooked.

The name of the inspection bureau in your state, offering the service of Stock Fire Insurance company engineers, will be sent on request—also a copy of "Fire Prevention and Protection as Applied to Hospitals."

### THE NATIONAL BOARD OF FIRE UNDERWRITERS

85 John Street, New York

Chicago  
222 West Adams Street



San Francisco  
Merchants Exchange Bldg.

*A National Organization of Stock Fire Insurance Companies « Established in 1866*



# THE MODERN HOSPITAL



A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.

VOL. XXXIX

July, 1932

NUMBER 1

## Should the General Hospital Treat Mental and Contagious Cases?

By F. G. CARTER, M.D.

Superintendent, Ancker Hospital, St. Paul, Minn.

**W**HETHER we who are in charge of general hospitals want them or not, we are at one time or another confronted with the task of caring for mental, tuberculous and contagious cases because of circumstances over which we have no control.

Any of these disease conditions may exhibit their first recognized symptoms during the period when the patients afflicted with them are undergoing treatment in the hospital for other maladies. Admitting diagnoses may be erroneous and the patient who entered the hospital as a case of pneumonia may be a victim of far advanced pulmonary tuberculosis. A spirit of compassion may have moved us to receive the patient who is too sick to turn away, although ordinarily our doors are closed to those suffering from this particular ailment. Zealous doctors have been known at times (and this isn't entirely to their discredit) to stoop to little "fibs" to obtain for their patients the care they know is needed. These experiences are familiar to all of us, yet we seem to be not so much concerned with the problem of giving them adequate care as we are with ridding hospitals of them as promptly as possible.

There must be something about these patients

that makes them undesirable and we should be interested in discovering just what that something is. Those in the mental group may be noisy, destructive, untidy, unsociable and generally uncooperative. They may use obscene language or they may have homicidal or suicidal tendencies. Generally speaking, they are not persons with whom mentally normal people like to associate. Tuberculous and contagious patients may transmit their afflictions to attendants, visitors or other patients. These difficulties are not insurmountable and in themselves do not seem to be adequate reasons for excluding such cases when we know that we can overcome the objections cited through proper construction, proper regulations concerning the handling of patients and proper training in the technique of caring for them.

### *Tradition Is to Blame*

What then is the background for our refusal, in most instances, to accept these three groups of patients? If we dig down deep enough into our innermost thoughts, I think we shall all have to admit that the crux of the whole situation is found in the respect we have for the traditional fears and prejudices that exist against these diseases

in the minds of those we serve or expect to serve. We are afraid to take such cases for fear of what will happen at the box office.

This state of affairs cannot be treated lightly or ignored, even though most thinking hospital people are convinced of the feasibility of satisfactorily caring for these three groups of patients for short periods at least in the general hospital. Public opinion, regardless of whether or not it is based on sound premises, is a formidable foe and it would be foolhardy for us to attempt to change it unless we are prepared to show that with modern methods in modern hospitals there is no factual basis for the fears and prejudices of past generations and that there are, moreover, numerous advantages to be gained by the public, the patient, the physician, the nurse and the hospital from a program that would provide care in the general hospital for mental, tuberculous and contagious patients.

Hospitals really have only two major objectives: the care of the sick and the education and training of all who come in contact with them. Anything that advances these interests advances the interests of the public, for no one knows when he may become a patient and if he does he wants the best possible care and service. In return for the support accorded, the hospital can make no greater contribution to its community than a better general level of hospital, medical and nursing practice and it is with this matter that the public is primarily concerned. They want to be assured of the best care obtainable when they or their loved ones need it and they are interested in the medical and hospital aspects of public health and of public safety.

#### *Why Discriminate?*

We have been told repeatedly that the policies of the hospital must be dictated by the "good of the patient," yet we discriminate ruthlessly against large proportions of the sick of the country who, though they are able and willing to pay for proper care, are outcasts, as far as obtaining conveniently located hospital service is concerned. A few weeks or months of sympathetic and competent attention at a time when they need it most might restore them to normal health and lives of usefulness. A few weeks or months of neglect may condemn them to death or even worse. Furthermore, these groups of patients are just as much in need of varied medical attendance as any other group and they can best obtain the benefits of consultation with representatives of all the medical and surgical specialties in the general hospital.

The care of these patients would increase the educational values of hospitalization for both pa-

tients and public. They would learn to know and to advertise the importance of early diagnosis and would come to understand accepted methods of preventing the spread of disease. Under proper management (and no institution should undertake this program unless its officials thoroughly understand and are willing to carry out faithfully the principles of proper management) the welfare of other patients would not be jeopardized.

#### *What the General Hospital Can Do*

In our medical assemblies much has been said of the importance of early diagnosis and treatment, but the medical profession will never become qualified to carry such a program to its greatest fruition until such time as its interest is stimulated generally through opportunities to study the diseases for which early diagnosis and treatment hold so much for the future. The antituberculosis campaign has made more progress in the last twenty-five years than in all of the centuries preceding, but its effectiveness is falling short of its possibilities because we are not training all of our physicians for active participation in this work by making material for study available to them. With the tuberculin skin test, the x-ray, the clinical laboratory and volumes of clinical experience available, I can't help voicing the feeling that we are on the threshold of the greatest conquest in all history. In my own and other communities we are doing tuberculin skin tests on high school seniors each year. It seems to be well established that those reacting positively to the test have had a tuberculous infection at some time. The vast majority have recovered from this infection without even knowing that they had it, but among the positive reactors we may look for the active cases, so we x-ray their chests and find them.

Of what avail is this work if the general hospitals refuse to accept the active cases for isolation and treatment and the suspicious cases for observation and study? Many patients refuse to go to tuberculosis sanatoriums because they feel that by so doing they are stigmatized, but they will gladly go to general hospitals. For similar reasons, many of the mildly mental cases refuse to enter hospitals for the mentally ill, although they would willingly submit to treatment in hospitals of their choice.

#### *A Potent Educational Force*

The educational obligations of hospitals have not been sufficiently stressed. The groundwork for a life of medical practice is laid in the medical school, but the most potent force for the education of the physician is found in the hospitals of the country. If we are to return to our benefactors

better trained, better educated, better qualified physicians, more intelligent nurses and more efficient hospitals, we must open our doors to all diseases to the end that all of us may have broader developing influences and greater incentives to the study of disease in a generic as well as a specific sense.

Progress in any field depends upon widespread, bit by bit, application of known facts to the unknown, with constant realignment and reshaping of forces. As the process advances, new concepts are formulated, new sciences are evolved, the strategy of attack changes, incentives multiply and superior results are achieved. In American medicine and American hospitals have we been sufficiently cognizant of our weaknesses and our opportunities? Have we contributed as rapidly and as generously as we might to the progress of medical science by making our hospitals laboratories for the advancement of knowledge concerning all the aspects of the care of all those who are sick?

#### *Completing the Nurse's Training*

The training of a nurse is not complete until she understands the principles of caring for mental, tuberculous and contagious cases and, without patients requiring the types of care involved in these groups, no hospital, in my opinion, can offer a well rounded course of nurses' training. None of our obligations is more binding or more neglected than that of teaching methods of preventing the dissemination of disease. That this knowledge is ours to command is evidenced by the experience of modern contagious hospitals in preventing cross infections. The well trained nurse, by reason of her numerous contacts, is perhaps the one who is best fitted to carry on this important specialized work.

It is true that many of the cases in at least two of the groups under consideration are chronic. In this connection it may be said that most acute cases are either self-limited or are amenable to special forms of therapy. The ones that need our help are the chronics, and as long as we continue to pursue a "capture and control" theory of treatment, they will never get it. The handful of men and women who are devoting their lives to this work need assistance, and this will come when we create broader opportunities for the study of these diseases. In the present state of our knowledge, I do not advocate prolonged care in general hospitals in all instances, but it should be kept in mind in these days when from 35 per cent to 50 per cent of hospital beds are vacant, that a number of chronic cases make a mighty fine backlog from a budgetary standpoint.

At the present time, a concerted effort is being made to induce the government to abandon its plans for the construction of numerous hospitals for veterans, substituting a plan for hospitalizing and treating these men in civilian hospitals. When private organizations fail to interest themselves in the hospitalization of any considerable group of patients, the local, state or federal governments will inevitably take over the work in response to the demands of the citizenry. If civilian hospitals had manifested the proper interest in the hospitalization of veterans ten years ago when this work could have been had for the asking, we would not now be confronted with the difficult task of interrupting a movement that has already gained enormous momentum. A large proportion of the facilities for caring for mental, tuberculous and contagious patients are government owned. They are inadequate and there are still plenty of opportunities for the general hospitals in this field. We should take advantage of them before it is too late. If we don't, we may sooner or later find ourselves in the same position with reference to these groups of patients as we now occupy with reference to the hospitalization of veterans.

The precedent for accepting in the general hospital the group of patients under consideration has already been set, and it is to the pioneers in this work that we must turn for the evidence which will break down the fears and prejudices that exist in the public mind. I know of one community of about 100,000 population in which there are two excellent private hospitals taking care of practically all of the hospital needs of the city. Both agreed to accept tuberculosis and contagious diseases. Both were well equipped to handle them properly. The public was offered no alternative and is being educated secondarily. The decision to accept or reject the group of cases in question was simply one of "do or don't" in this particular city. All communities, however, are not so fortunately situated.

#### *Making Hospitals "General" in Fact*

Where there are many hospitals, one can ill afford to risk the loss of its clientele by embarking upon such a program alone. Local conditions and local strategy will have to determine the approach. If this program is to be undertaken, the initiative must come from the smaller communities having only one or two hospitals. Once under way, their experience will be drawn upon by the larger cities in carrying out educational programs as a preliminary to the introduction of similar policies concerning the admission of mental, tuberculous and contagious patients to their own institution.



It may be emphasized, then, that if general hospitals are to be general in fact as well as in name; if prejudices and fears based only upon tradition and superstition are to be relegated to the scrap heap where they belong; if we are interested in offering elective hospital service to a large group whom we now seek only to reject or eject and who are now outcasts as far as obtaining care and treatment in hospitals of their own choice is concerned; if we are to raise the general level of hospital, medical and nursing service through proper emphasis upon the educational function of the hospital; if we are to educate the public in matters of health; if we are to cease stigmatizing the patients and families of these groups; if we are to serve community interests efficiently; if we are seeking methods of balancing our budgets; if we are interested in keeping the government from expanding its hospital interests; if we honestly believe that "he profits most who serves best," then we can only answer in the affirmative the question, "Should general hospitals extend their services to mental, tuberculous and contagious patients?"<sup>1</sup>

### California's New Research Project on Mental Health

Modern methods of science are employed to strengthen the mental health of California, according to Dr. J. M. Toner, director of the institutions for the state. Eighty thousand dollars is now available for the construction of a state central research pathological laboratory to be located at Agnew's State Hospital, Agnew, Calif. Appropriation has also been made for a \$50,000 biennial support fund for the project.

The laboratory, the first of its kind in the United States, when completed will cause vigorous stimulation to be given those charged with the purpose of administering California's institutions by enabling them to attack the ever increasing mental problem in a scientific manner.

Comparatively little has been done heretofore in the way of prevention of brain diseases, Doctor Toner says. Mental disorders are similar to those of other body illnesses, and recognition of this fact is of inestimable value. This increasing sentiment among the medical profession will be greatly enhanced by the construction of the new laboratory. Human behavior in relation to certain body gland disorders, physiological imbalances, offers to the research minded scientist a wide field for study available only through the construction of Cali-

fornia's new research project. The wide clinical field now offered by the department of institutions will be materially utilized to the end of effecting some good in improving the mental health of the state.

The department of institutions recently introduced the use of diathermy apparatus that produces artificial therapeutic fever for the treatment of general paralysis of the mentally ill. This disease, a contributing factor of insanity, was considered hopeless a few years ago. With the modern application of science, great progress has been made. Such well equipped scientists as Dr. Herman Adler, state psychiatrist, and Frederick Proeschner, state pathologist, by reason of their wide experience, will be of great aid to the department upon completion of this new project.

The six state mental hospitals and the two institutions for the feeble-minded have a patient population of 18,960, and according to departmental reports, this rate is evidently increasing. The rapidly changing conditions of society tax the nervous system considerably, probably one of the contributing causes of mental disturbances among people who would sooner or later require state hospitalization. Therefore, it becomes absolutely necessary to formulate some tangible plan of prevention so as to relieve the taxpayer of this ever increasing burden.

### Acquainting Trustees With the Best in Hospital Practice

How Charles H. Dabbs, general superintendent, Tuomey Hospital, Sumter, S. C., plans to acquaint the trustees of his hospital with the latest and best in hospital practice is told by Mr. Dabbs himself as follows:

"I am planning to circulate THE MODERN HOSPITAL and other hospital publications to our trustees, all of whom except one are nonmedical men.

"The plan is to paste on the cover a mimeographed list, showing the order in which the publications are to be forwarded. Each member will have them in his possession for one week.

"I am sure this plan of reading will stimulate their interest and enhance their understanding of hospital problems."

The mimeographed list contains the names of the trustees, with the date they are to receive the publications opposite each name. Preceding the names, is this sentence: "Board members are requested to read the items of interest found herein and forward to the next named not later than the date indicated."

<sup>1</sup>Read at the meeting of the Tri-State Hospital Association, Chicago, April 27, 28 and 29.

# An Experiment With Group Nursing That Augurs Success

By JOSEPH TURNER, M.D.

Director, Mt. Sinai Hospital, New York City

THIS report of a brief experience with group nursing in the new pavilion for patients of moderate means, Mt. Sinai Hospital, New York City, can scarcely be considered as more than a preliminary report since it is based on a period of operation of five months, too short a time on which to predicate conclusions. It may be said, however, with certainty that the plan is functioning satisfactorily and gives every promise of continuing to do so.

It is not necessary to go into the merits of group nursing of this kind as compared with improved floor nursing or other forms of nursing care, nor do I wish here to review the experiences of others with group nursing except to say that group nursing has been tried in a number of hospitals, often with discouraging results. There have been a few exceptions, one of which is the group nursing plan

that has been in successful operation for several years at Grace Hospital, Detroit. An examination of the reported failures seems to show that they have been due not so much to any fault in group nursing as such, but to faulty planning; most of the rooms or buildings in which group nursing has been tried were not built for this purpose, nor were they designed or equipped in such a way as to assist in making group nursing acceptable to patients or workable for nurses.

Group nursing, in a broad sense, is not new. Ordinary floor or ward nursing by graduate or student nurses on general duty is group nursing. Group nursing is nothing more than a provision of nursing care for a group of patients by one or more nurses. But the group nursing plan which is described here refers entirely to nursing by graduate nurses who are employed solely for this pur-



*This four-bed room has been especially equipped for group nursing.*

pose, who are assigned to definite patients in restricted semiprivate wards during certain periods and who have no other duties whatsoever. It might be described as cooperative nursing, cooperative in the sense that several patients cooperate in a nursing plan for their common benefit.

Group nursing in this new building was not a haphazard affair, lightly entered into. In order to give it a fair test, the building was planned to make a group nursing service possible, and yet was kept flexible enough to permit ordinary floor nursing or special nursing to proceed simultaneously in adjacent wards or rooms without waste of space or useless duplication of equipment. In the study of plans, the hospital administration had the assistance of Dr. S. S. Goldwater, New York City, the board's consultant.

The floors consist of six large rooms, containing four beds each, supplemented by a few quiet or isolation rooms for patients requiring separation for clinical reasons. The typical room is 21 feet wide by a little more than 17 feet deep; the beds are in cubicles separated by curtains. The floor area exceeds 360 square feet so that the floor area per bed is more than 90 square feet. Each room has two windows overlooking Central Park. Each room is provided with four built-in lockers for patients' clothes and a built-in closet for nursing supplies in daily use. A wash basin is in a corner.

The patients' rooms are arranged in pairs with a subutility room and nurses' substation between. The subutility room is isolated from the patients' sections by appropriate acoustical treatment, and is fitted with essential equipment, including a counter shelf cabinet with cupboard space above and below, a general utility sink with a drain board, a built-in bedpan washer, a bedpan rack, a hopper sink, open shelves for supplies in daily use, a gas stove, electrical outlets and nurses' signals. This utility room is ventilated by a window facing the street and is connected further with the central exhaust ventilation so that air enters this room and odors cannot permeate the adjoining patients' rooms. Between the corridor wall and subutility room, and separated by a passageway connecting the two patients' rooms through double acting self-closing doors, is a small nurses' substation, partitioned off and equipped with desk space for two nurses, a medicine cabinet, a bulletin board, nurses' and orderlies' signals, chart racks and supply drawers.

#### *How the Floors Are Planned*

Each floor contains three pairs of four-bed wards, each with a connecting utility room and nurses' local station. There are, in addition, separation or quiet rooms, a sun porch with east, west

and south exposures and an enclosed day room for the use of convalescent patients. At each end of each typical floor there are patients' toilets and baths. A central nurses' service unit (supplementing the distributed subutility rooms already described) is provided with airing closets, a dryer, a blanket and solution warmer, an instrument sterilizer, a utensil sterilizer, a worktable with a built-in gas plate, a cupboard and cabinet with a counter shelf, a utility sink and drain board and a refrigerator with separate compartments for cracked ice, biologic products and laboratory specimens.

#### *Facilities Are Flexible*

Overlooking the entrance and elevator lobby is a central nurses' station having a medicine cabinet and sink, chart racks and desks, and provided with the doctors' and nurses' signal and paging system. Near by are linen closets, storage closets, telephone booths, a small reception room for patients' visitors, an orderly's station, a linen chute, a drinking fountain and a mail chute. A pantry centrally placed is serviced by two elevators with direct access through a common vestibule, which helps to keep noisy traffic and cooking odors out of the patients' corridors. A cleaner's closet opens into this vestibule. Each floor also contains an examining and a treatment room with a steam sterilizer, a scrub sink and other appropriate equipment.

The floor facilities were planned in a flexible way, permitting their use at will for the experiment with group nursing, for floor nursing which would be needed to some extent in any event and would certainly be needed if group nursing did not prove satisfactory, and also for special nursing if and when it was required. All of these services can be maintained simultaneously on any given floor without conflict and without confusion.

To have planned and built accommodations for patients at a half to a third of the rates prevailing in private rooms would have been a half-hearted gesture toward the lowering of the costs of hospitalization if certain other charges had remained stationary. Laboratory service and x-ray service were therefore priced at from 50 per cent to 60 per cent of private room rates. A certain number of patients would always be eager for special nursing service or its equivalent, but the cost of individual private nurses was prohibitive and special nurses whose names were carried on the hospital registry were idle for much of their time. Since there had to be some way of lowering special nursing costs, group nursing seemed to offer an answer that would benefit both nurses and patients.

Several plans were prepared by Elizabeth A.



Greener, superintendent of nurses, based on the grouping for nursing purposes of four patients and eight patients respectively. Alternate plans were prepared on the time basis of a twelve-hour nursing day and an eight-hour day. After thoughtful review, one of these plans, employing an eight-hour nursing day, was put into operation on the day the new building received its first patients.

special staff of carefully selected graduate nurses, organized in collaborating groups for continuous or twenty-four-hour duty. Under this plan a nursing team is assigned to a small number of patients occupying adjoining cubicles, all under direct control from a well equipped local nursing station. The physical arrangement is such as to ensure constant contact of nurse with patient and to facil-

*Located between two four-bed rooms, this sub-utility room facilitates group nursing. In addition to the equipment visible this room has a supply cupboard above the work counter at the right and a built-in bedpan washer, partly concealed by the drain board of the utility sink.*



In order to acquaint the patients with the plan and to point out the differences between group nursing and other types of nursing, a circular of information was prepared. The circular pointed out that "Three types of nursing care are offered to patients admitted into the pavilion for patients of moderate means. In order that proper room assignments can be made, patients are asked to indicate their choice at the time they apply for admission.

"1. Group (cooperative) special nursing: This is a superior type of nursing service supplied by a

itate immediate attention to patients' needs. The hours of duty likewise are arranged to ensure a maximum of individual nursing care, and uninterrupted service by the same nurses is assured throughout the patient's stay. The plan may be described briefly as one of cooperative special nursing. The cost to each patient (less than the cost to the hospital) is \$6.50 a calendar day or fraction thereof for day and night nursing combined. This type of nursing service is recommended by the hospital, and is available only to patients occupying designated group rooms. Pa-

tients transferred to other rooms or sections of the hospital cannot be provided with this service.

"2. Individual special nursing: This is a type of service wherein the patient receives the exclusive services of a graduate nurse for the day or night, or both. A patient who requires this type of nursing is charged \$119 a week for both day and night nurse, or \$8.50 for each day or night. Nursing of this type is recommended only for those patients who are so ill as to need the continuous and exclusive service of special graduate nurses and is permitted only when requested by the attending physician or surgeon.

"3. General floor nursing: This nursing care is rendered almost entirely by student nurses whose services are shared by all patients on floor care. Student nurses are unavoidably subject to frequent change in floor assignments and in hours of duty, due to the exigencies of their educational program. This type of nursing service is supplied by the hospital without extra charge."

#### *How the Plan Works*

In describing now the group nursing plan itself, we shall consider first a unit of four patients. Four nurses are required to serve this group over a period of twenty-four hours. Two nurses are on duty from 7 a.m. to 3 p.m. to care for the patients during the time of day when most nursing care is needed, when baths are given, dressings done, rounds made and two meals served. One nurse serves the same four patients from 3 p.m. to 11 p.m., which includes the visiting hours and service of one meal, and one night nurse serves from 11 p.m. to 7 a.m. when the need is lightest. Each nurse serves these eight hours daily for six days in a week. To give nursing on the seventh day, relief is needed for four eight-hour nursing periods, or the equivalent of two-thirds of the time of an additional nurse in a week. A complete unit of two rooms of eight patients will then require the services of eight nurses plus one and one-third relief nurses.

Several time studies of nursing service on various wards have shown that the actual number of hours devoted to bedside nursing—time spent on wards and floors for patients—if apportioned among all patients on each ward or floor, would show an average of three and one-half to five hours daily, with variations due to the sex, age and clinical character of patients. The group nursing plan as described provides a minimum average of eight hours of actual bedside nursing for each patient; with fewer patients in a group the hours of nursing service for each patient increase. If the supplementary service of the orderlies is included in the calculation (orderlies actually serve

as male nurses in many ways) the hours of nursing service would be increased further.

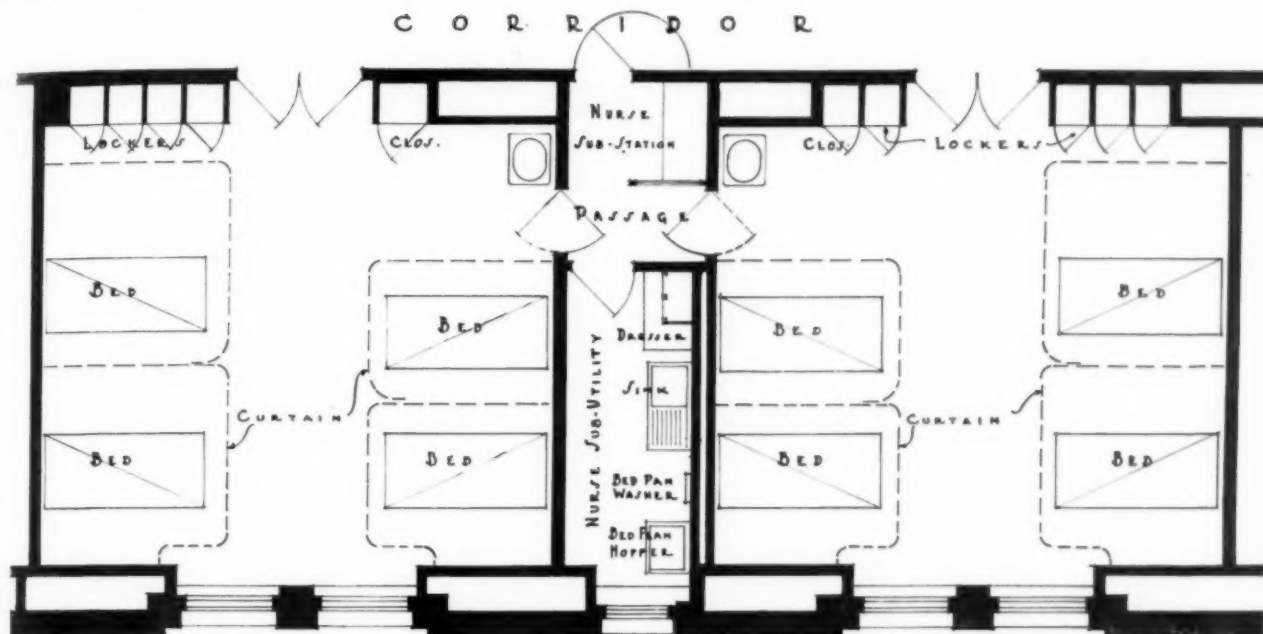
The mere mention of these figures of nursing service in terms of hours of service, however, does not present a complete picture for comparative purposes, for some allowance must be made for the difference in the quality of an hour of nursing by an experienced graduate nurse and an equivalent period of nursing by an undergraduate or pupil nurse in various stages of training. One might ask for a definition of an hour of nursing in order to afford a basis of comparison, but an acceptable definition is not easy to find. An hour spent by a nurse on a large ward or a floor with long corridors, where the service units are inconveniently placed and imperfectly equipped, is one kind of nursing hour, whereas an hour spent on a floor where all essential nursing facilities and equipment are close at hand, is quite another matter. The hour of nursing service in the group nursing unit in this new building is the nearest approach to an hour of actual bedside care that it is possible to provide, short of putting every possible item of nursing service equipment beside each bed.

The accompanying plan will show the arrangement of the services. The proximity of the clothes locker, the supply closet with its linens, the instrument tray, the dressing drum, dressing jars, the nearness of the sink, the bedpan and other facilities, mean a saving of many steps and of much time for actual nursing service. The equipment stored in the special bedside table that stands at the side of the bed nearest the nurses' station also saves time and energy.

Using two four-bed rooms as a complete unit, four nurses are found during the morning and early afternoon hours serving eight patients from one subutility room and nursing substation. When two nurses go to their noonday meal, the other two remain, one in each room, to give necessary service. Two nurses, one in each room, are on duty during the late afternoon and night periods, when there is less nursing to be done. These two nurses relieve each other for meals.

#### *Patients Are Well Pleased*

Group nurses are paid \$130 a month and are allowed two meals daily. This averages \$5 for each working day. No residence and no laundry service are provided. One day off is granted each week; there is no vacation period with pay. The present charge to the patient for group nursing is \$6.50 for a day of twenty-four hours. Were four patients constantly paying \$6.50 each a day for nursing while the hospital was paying but four times \$5 a day to its group nurses, there would be a small



This plan shows a typical unit for group nursing for patients of moderate means, Mt. Sinai Hospital, New York City.

surplus after allowing for the value of the nurses' meals. But all beds are not occupied all of the time; there are periods of lessened occupancy and reduced income not accompanied by a corresponding reduction of costs. Thus, with three patients in a room it would still be necessary to have four nurses and with two in a room, three nurses, one for each of the shifts, in which cases the sum actually paid by patients would not even meet the pay of the nurses. Any surplus income obtained by the hospital when the groups are full helps to make up losses due to lowered bed occupancy and lowered income. An analysis of income and costs made after the first three months, showed that due to the comparative constancy of the demand and the watchfulness of the supervisor in arranging the service schedule, the hospital was able to provide group nursing at a cost of a fraction less than \$6.49 a patient day.

The hospital's policy with regard to group nursing is predicated on the principle that there will be no exploitation of nurses, and that no profit will be derived from this service. If a longer experience shows that the service can be rendered for less than \$6.50, the charge to the patient will be lowered to cost figures. Even if it becomes necessary to make good a small loss, the hospital will try to keep the rates down. Even at a loss, it would be advisable to continue the service on the principle that the cheaper nursing costs can be made to these patients, the more patients will be able to afford it and the more will avail themselves of it. This in turn will increase the demand for group nursing and create more opportunities for steady work for graduate nurses. Group nursing opens a new mar-

ket for extra nursing service to a group which heretofore has not been able to afford private nursing.

Have the patients found group nursing satisfactory? So far as the quality of nursing is concerned, the patients are well satisfied. Nearly all who need extra nursing obtain it in this way with a welcome saving in cost. The need for nursing service requiring the exclusive use of special day and night nurses at \$17 for twenty-four hours is comparatively rare. As will be noted from the circular of information prepared for these patients, special nurses on regular twelve-hour duty may be had only with the consent of the attending physician or surgeon. To date, approximately one-third of the patients in this pavilion are on group nursing care every day. According to reports, more would like to be, but even at this relatively low cost, it is beyond the means of many.

Of the medical staff, a number looked askance at group nursing in the beginning, but most of these are coming around to the view that this form of group nursing is meeting a distinct need. They have found that it provides a grade of nursing service which satisfies the requirements of nearly all of the patients who need more than floor care. Some have asked whether group nursing could not be introduced into the private room sections. This is doubtful. Group nursing on floors wholly given over to single rooms has not been generally found successful in hospitals which have thus far reported their experiences. The failures are due probably to the physical arrangement of hospital floors which did not lend themselves properly to group nursing. In other words, group nursing,



to be really effective, must be arranged for patients housed in groups conveniently placed and conveniently served.

Floor nursing administration does not concern the group nurses; this is cared for by a charge nurse who is also responsible for the pantry service. The patients' trays are set up by this charge nurse assisted by a maid and wheeled to each unit in carts holding eight trays. However, the pantries are equipped with a four-burner gas range permitting as many as four nurses to use it at the same time for any particular preparation of patients' trays. Others may use the hot plates in the sub-utility rooms to warm food.

In operation a group nursing plan is not all perfection. Problems arise daily requiring adjustment. There are, for example, the problems arising from having two, three or four patients with different temperaments and fluctuating and sometimes conflicting demands in one room. While this is a problem which must be faced by group nursing, it is not one that is specifically created by the group nursing plan, and it has not been found as troublesome as might be supposed. One difficulty is the transfer of patients in and out of group nursing units. For reasons of economy, some patients elect to use group nursing only as long as they need extra nursing care. This requires the moving of patients in and out of group nursing sections. In anticipation of this, beds were provided with easy rolling casters, the bedside table was made mobile and the doors and corridors were made wide enough for easy transfer.

#### *Compensations of Group Nursing*

Group nursing has brought with it a number of compensations. It has, in fact, corrected one thing that has always been troublesome in private room service—the complaint of delay in answering a call. It helps little at such times to explain that the number of patients is in excess of the number of nurses and that the number of calls sometimes is greater than there are nurses to answer. The private patient waiting in the room is not always in a position to know whether a call has been received or what the nurse is doing at the moment, and the danger and discomfort of a few minutes' delay become unduly magnified by the wait. But with four patients in a room, the patients actually see the nurse about them and will usually postpone their calls until they see that the nurse has completed the task in hand and is free. Even if they do call, they know that their need is known, and that they will be served in their turn. The nurses also can, in case of real need, temporarily interrupt or abandon one service in order to meet a more immediate and urgent need.

As was said in the beginning, this is a preliminary report, for it is far too soon to speak of the permanently satisfactory results of a stabilized system. Even now, however, one can say first, that group nursing has been functioning at Mount Sinai Hospital for five months, that it has been successful so far, that patients and physicians appreciate the service rendered at a cost below that of individual special nursing and that the graduate nurses who have cooperated to make the plan possible are satisfied with it, not only because of the eight-hour day and six-day week, but also because of the relative continuity of employment and regularity of earnings which compare more than favorably with the employment and earnings of most of the nurses who are now doing special nursing.

---

### Should the Superintendent of Nurses Make Night Rounds?

It has been frequently remarked that the hospital at night is an entirely different type of institution from that observed during the daylight working hours. Even the appearance of wards and rooms seems to change, and patients who are particularly ill require almost as much supervision during the night as they need during the day hours.

The superintendent of nurses who does not fully know her institution during both of these periods is neglecting a possibility for service that offers much along the line of improved nursing. The head of the training school should not let a week go by without being seen within the hospital at some hour of the night. This very uncertainty as to the time of her coming adds to the value of her visit. To be sure, every institution worthy of the name possesses a wide awake and efficient night superintendent who reports to the head of the school each morning. Yet the superintendent should not always be satisfied with second-hand information as to the morale and the functioning of night nursing service. Indeed, it is a most useful custom for the superintendent of the hospital and the superintendent of nurses occasionally to make complete night rounds.

The night in the life of the sick is an endless period of time, and instead of diminishing the active service to the sick as is done in many instances, it should be accentuated during this period. The wide-awake superintendent of nurses knows no night or day unless she has become so institutionalized that at the end of her day she routinely relinquishes her duties to someone else.

# How the Administrator May Solve His "Depression" Problems

By ARA DAVIS

Superintendent, Scott & White Hospital, Temple, Tex.

IN THE face of the most greatly disturbed economic conditions any of us has ever experienced, the greatest problem confronting the hospital administrator today is that of making ends meet financially. This is a problem that challenges more administrative genius than most of us possess. It necessitates more studious attention to collections than was necessary in the past, since most hospitals doubtless are collecting as much as their patients are able to pay. For this reason we do not have much latitude in the matter of increasing our income. The only other alternative, therefore, is to decrease our expenses, and this is the phase of hospital administration that is of most concern to us.

The best way to control hospital expenses lies in the adoption of and adherence to a carefully prepared budget. Although we discuss budgets at length in our hospital meetings, the average hospital is still trying to get along without going on a budget basis. The present depression, however, is offering us perhaps the best opportunity we shall ever have to adjust our business and place our institutions on a strictly businesslike basis. Since the powers that are behind hospital organizations are now more disposed than ever before to lend their full cooperation toward the accomplishment of a more economical administration, those hospital administrators who have not yet put their institutions on a budget basis will find the time opportune to do so. There is no question but that budget control of expenditures is essential to efficient hospital administration.

## *Loyalty Must Be Maintained*

In our retrenchment programs most of us have doubtless been confronted with the problem of cutting salaries. This is something all of us dislike to do; yet under present conditions salary reductions are not only necessary but are perhaps justified by reduced living costs. The person who receives the same salary today that he did two years ago is better off now than he was then, and the person who receives from 15 to 25 per cent less now than he did two years ago is approxi-

mately as well off, since the buying power of his money has increased materially. A reasonable salary reduction, therefore, is not out of line, although we must be fair and thoughtful in our salary reductions and take care not to lose the confidence and loyalty of our employees. No institution can survive and prosper that does not have the loyal cooperation and support of those who constitute the personnel of its administrative staff.

## *Buying Problems and Their Solution*

One of the problems I have had to contend with has been a disposition on the part of department heads to insist upon personally ordering their own supplies and keeping these supplies in their different departments for use as they are needed. Of course, I realize this problem has perhaps not been experienced so frequently by those who operate other types of hospitals—ours is a private hospital—but the management of our institution is more or less of a family affair, and department heads have been given practically a free rein to do as they pleased. As a result, they have considered it an encroachment upon their personal rights and liberties to be denied the privilege of ordering and using whatever they have desired. We have succeeded, however, in creating a centralized purchasing and distributing system, and this change in administrative policy is resulting in material savings. One person giving specific and personal attention to buying for an institution can undoubtedly qualify to buy more economically and to better advantage than can half a dozen department heads buying indiscriminately, and without any particular interest in prices and often without knowledge of the quality of the supplies purchased. With so many houses now offering inferior products at reduced prices, more skill is required in purchasing than ever before. By centralizing our purchases, we have not only been able to get better prices but a better quality of merchandise also, and by centralizing the distribution of supplies we have been able to keep a closer check on the quantities used by the different departments, thereby effecting certain savings.

Another problem that many hospitals are facing now is whether or not to continue operating their nurses' training school. This is a problem we are facing along with the others, but we have not as yet reached a definite decision. Training schools are expensive to maintain, and it is questionable whether they pay their own way. Many hospital administrators claim they can take care of their nursing requirements more economically and more satisfactorily otherwise. Then, too, it is evident that we are rapidly accumulating a surplus of graduate nurses. In view of the thousands of graduate nurses in the country now who cannot find work to support themselves, it is doubtful whether hospitals are justified in continuing to operate training schools and to turn out more graduate nurses. Every hospital administrator should give this question careful consideration.

#### *The Satisfied Patient—The Best Advertisement*

Malicious and unfounded rumors may present a definite problem. During the last few months few institutions have escaped attacks by the subtle tongue of the scandalmonger. I have repeatedly heard false reports to the effect that certain hospitals in different sections of Texas have gone bankrupt and have ceased operation. False reports have even come from other states to the effect that some of the largest and strongest medical organizations in the country have been compelled by reason of the depression to close their doors. These reports have doubtless been the outgrowth of retrenchment programs. When an institution cuts salaries or reduces its working force, there is always someone around ready to speculate that it is in serious financial difficulty. Others enlarge on the speculation, until finally the report becomes current that the institution is bankrupt and out of business. We have had this situation to deal with, and I can name a number of other hospitals about which similar false gossip has been circulated to their great detriment and injury. If anyone can suggest a satisfactory way to deal with rumors of this character, the suggestion will be gratefully received.

The question of how far we can or should undertake to go in the care of nonpay or charity cases is another problem that must be faced, especially by operators of private hospitals who have no special fund available for the care of charity patients. Doubtless every hospital during these trying times could keep all of its beds filled with nonpay patients, since countless numbers of unemployed persons are compelled to seek charity. While every institution must, of necessity, adopt policies along this line for its own protection and survival, we must, nevertheless, do our share of

charity, and not seek to shirk the responsibility that is rightfully ours.

With most of us the question of how far we can go and how far we should go in the matter of advertising is rather an acute problem. There is one medium of advertising, however, that is not involved in ethical considerations or restricted by economic conditions, and that is the satisfied patron. After more than twenty years of service in the hospital field, I am convinced that no other type of advertising can bring results comparable to the expressed good will of satisfied patrons. In these days of financial distress when we are curtailed in publicity programs, we still have recourse to this most productive and lucrative of all forms of hospital advertising. If this period of economic stress brings us to a fuller appreciation of the good will and friendship of our patrons and causes us to intensify our efforts to send each one forth as a booster for our institutions we shall find that it has been of real service to us.

While we are struggling against adverse financial conditions and are seeking everywhere for opportunities to cut expenses, we are likely to be tempted to apply cuts that affect our service to our patients. When we do this we are doing something that is exceedingly unwise if not unwarranted. We ought not ever to lose sight of the fact that service to the patient is the chief function of every hospital. This is something that must be preserved regardless of all things else, for the hospital that disregards its obligation to the patient forfeits its right to survive. The finest thing about hospital work is the opportunity it gives us to render a splendid service to those in need, and the fact that hospitals generally are looked upon as places where the most generous, thoughtful and humane service is expected and realized stands to the everlasting credit and glory of the hospital administrator.<sup>1</sup>

### U. S. Spends \$13,000,000 for Veterans' Hospitals

New hospitalization construction throughout the country involving an expenditure of \$13,000,000 will have been completed by the end of the present year or the first two or three months of 1933, according to Brig. Gen. Frank T. Hines, Administrator of Veterans' Affairs.

One of the largest of these projects, General Hines said, is the new veterans' hospital at Columbia, S. C., which is expected to be completed on June 30 of this year.

<sup>1</sup>Read at the meeting of the Texas Hospital Association, San Antonio, April 8 and 9.



# Who Trusts a Trustee?

By HOWARD S. CULLMAN

President, Beekman Street Hospital, New York City

I HAVE been asked in this paper to define the functions of the trustee in social service, but I may as well confess candidly that I shall do nothing of the kind. The whole problem is a maze of intangible values, of necessities and obligations without boundary or exactness, of questions so vital and so human that they defy precise limitation. I am inclined, as I consider the subject, to echo the wise and melancholy comment of Judge Benjamin Cardozo concerning the "Paradoxes of Legal Science." So apt are his conclusions and so applicable to the paradoxes of social science, that I should rather quote than paraphrase them.

"They do things better with logarithms," says Judge Cardozo. "The wail escapes me now and again when, after putting forth the best that is in me, I look on the finished product and cannot say it is good. In these moments of disquietude I figure to myself the peace of mind that must come, let us say, to the designer of a mighty bridge. The finished product of his work is there before his eyes with all the beauty and simplicity and inevitableness of truth . . . no mere experiment has he wrought . . . yet unwritten is my table of logarithms. My bridges are experiments. I cannot span the tiniest stream in a region unexplored . . . and go to rest in the secure belief that the span is wisely laid."

I am afraid that anyone who approaches the field of social service honestly and earnestly is doomed to many such "moments of disquietude," more especially, the well intentioned layman who assumes the ambiguous rôle of trustee. No definite tasks are laid out for him. No neatly drawn line marks the point where professional responsibility ends and amateur duties begin.

## *Where Laymen Often Err*

In this, the social service trustee is even less fortunate than his confrere, the hospital trustee. I have, myself, on past occasions, delivered some rather positive statements as to the obligations of a hospital board. Correct or fallacious as these views may have been, they were open to argument only along straightforward factual lines. There is, I believe, no rational hospital trustee who claims that he can or should make daily rounds in the wards prescribing pills and potions according to his fancy. Certainly, in the hospital field, there is

a clear demarcation between professional and lay functions. If disputes as to responsibility arise, they can only be in the borderline region of administrative matters.

In the field of social service there are no such readily accepted distinctions. Even the most meddlesome hospital trustee will confess that you cannot have a hospital without doctors. Among social service trustees, on the other hand, there is often a strong, subconscious feeling that the whole job could, perhaps, be carried on without any professional staff and that if we must put up with a few paid workers they should be ruled and guided in their efforts by lay minds.

## *The Growth of Social Service*

Deplorable as this attitude may appear, it is not, I think, wholly fair or accurate to ascribe it entirely to human vanity. It had its genesis in the history of many of our leading social service enterprises. Characteristically, these organizations began long before the day of the psychiatric approach and even before indigent persons were known as cases. Commonly, a group of prosperous citizens gathered together to do what was then naïvely known as caring for the poor. This was an amazingly simple process. At a board meeting the plight of the Jones family might be discussed and ten dollars voted to them. This sum was forthwith handed to Mr. Jones, who was probably waiting in an anteroom, and the meeting would proceed to the Smiths' need of coal. At this historic or perhaps, from a social service point of view, prehistoric date, there were no professional social workers and the trustees did, in their amateur fashion, carry on their primitive benevolences without benefit of a single card index.

In this they differed radically from the founders of hospitals, for there is, in recent years, no record of anyone trying seriously to care for the sick without doctors. Many of these charitable groups, however, soon found themselves involved in a mass of detail work for which they had neither the time nor the inclination. It became a common practice to hire a clerk to remain in the office all day carrying out the mandates of the board.

To some board members, it has been a considerable shock, ten or twenty years later, to find this humble and menial creature transformed into an

executive director whose main preoccupation seemed to be the specialized and professional nature of his work, and it has further added to the trustee's confusion to have this imposing creature address him in terms of social techniques, psychological approach and behavior problems. Many board members have never recovered from this shock.

This lack of understanding can, to a certain extent be blamed on the staff members themselves. Comparatively new in his professional standing, the social worker has been overzealous to emphasize his technical equipment. He has striven to dehumanize his work and to impart to the social field the sacred aroma of the laboratory. Obviously, this is a fallacy. Useful as certain techniques may have proved in dealing with unfortunate human beings, the very name "social work" has a broad and general implication. The problems of society can never be solved with scientific detachment. They require far more than the earnest attention of any group of specialists.

Granted that such matters as office routine, selection of staff and expert investigation are professional matters in which the trustee has and should desire no part. These activities, viewed in perspective, are merely partial instruments toward an end which they can never achieve alone. Any social goal demands more than the service of an able and well trained group of experts. In giving his work the necessary breadth of scope, the strongest and most accessible ally of the executive director is his board, providing that he has built up a background of intelligent understanding.

No professional staff, however competent, can alone build up for a welfare program the widespread enthusiasm and interest which alone ensure its success. Board members, if they have been kept informed of their organization's purposes and progress, through active committee membership, are the surest available group of ambassadors to an uninformed world. It is through their informal propaganda that a community project can become known.

#### *A Two-Way Ambassador*

Herein is a second important function of the trustee. It is his job, not only to interpret the work of his organization to the community, but also to interpret the needs and spirit of the community to professional workers, to contribute to every project the knowledge and point of view he has gained in the laboratory of practical experience. By this I do not mean any vague or theoretic process. Social workers are equipped with certain techniques, with information and experience of a particular kind. They are not, how-

ever, trained to solve the problems of life itself. Even in such a reputedly specialized field as "case work," the theoretic social solution of a problem is often blocked by practical difficulties outside the province of the social worker.

It is, for example, possible for a professional worker to discover that a particular family would be immeasurably benefited, morally, mentally and physically by being installed on a farm. Assuming that the funds for such a move are available, there still remain a number of concrete problems to be met before such a move can be accomplished. The business of renting or purchasing a farm, the mechanics of the whole transaction, are matters in which the professional social worker is a complete amateur. Such a situation is typical of many that arise in social work, situations in which the assistance of lay trustees is no mere gesture but a vital and integral part of the task. Fortunate in the solution of such problems is the social worker who has the backing of a well informed lay committee.

#### *Wherein the Trustee Serves Best*

Especially real is this need of lay assistance in any attempt to ensure a welfare scheme by means of social legislation. Such an effort is practically doomed to failure if it depends alone on the efforts of a staff trained in social work but inexperienced in legislative techniques. The necessary drive and energy for such a task can only be provided by trustees who, through close contact with the organization, have absorbed its spirit and purpose.

It is doubtful if any such useful cooperation is ever obtained by the executive director who uses his board members as a convenient but intellectually insignificant money bag. Such a director is usually afflicted with what I may term the "problem trustee"—the trustee who likes to have his finger in the most insignificant problems of personnel, who is constantly fostering and engineering pet and usually irrelevant projects of his own. Exasperating as such a director is, from the standpoint of organization efficiency, his sponsorship even of money raising efforts is likely to be far less effective than that based on an intelligent and broad grasp of social purposes.

Such an understanding is not born overnight. It does, however, lie dormant, ready to respond to the stimulus of diligent and real cooperation in a common task. The effectiveness of a social service organization depends, I believe, on an intelligent awareness that the responsibility for true social service must be jointly shared by experts and laymen—a cooperation so sincere that questions of prerogative are dissipated in singleness of purpose.<sup>1</sup>

<sup>1</sup>Read before the Child Welfare League of America, Brooklyn, N. Y.

# How the Pathologic Laboratory Can Best Serve the State Hospital

By WALTER FREEMAN, M.D., Ph.D.

Director of Laboratories, St. Elizabeth's Hospital, Washington, D. C.

THE work of the clinicopathologic laboratory in the state hospital will depend upon two main factors, financial backing and the major interests of the director.

The day is past when epoch making discoveries may be anticipated from a lone worker who is not able to concentrate upon the problem of his choice because of the insistent demands made upon his time and energies by an alert clinical staff. A significant proportion of the time of the pathologist is and should be taken up by the performance of routine tests. Nevertheless it is irksome to him to carry out multifarious examinations that are requested as a matter of routine rather than as the outcome of definite clinical indications. Somewhere between rigid routine tests and pure re-

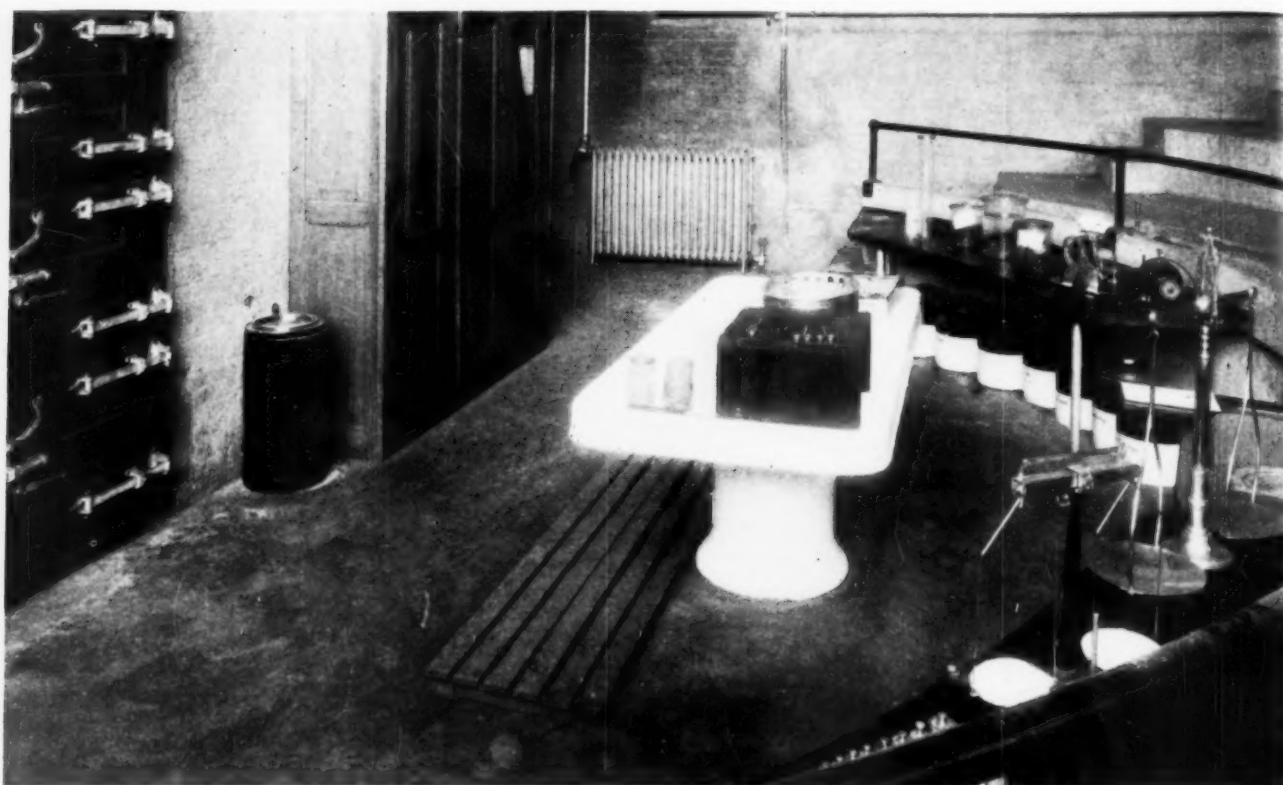
search there should be found a medium in which the pathologist can find satisfaction.

The state hospital offers opportunities for clinical observation over prolonged periods, and here many chronic maladies may be followed from their inception to their final termination. Thus the roentgenographic alterations in pulmonary tuberculosis may be followed not only from month to month but even from year to year, and the progressive alteration in the serologic manifestations of paretics treated by malaria may be followed for several years. On the other hand, the large number of patients renders complete investigation practically impossible, and cooperation on the part of the patients is not always easy to obtain. The best that the pathologist can hope to



One of the important divisions of Blackburn Laboratory, St. Elizabeth's Hospital, Washington, D. C., is the laboratory of clinical chemistry, pictured here.





*Autopsy work at Blackburn Laboratory forms an important part of the investigations carried out. This autopsy room has a seating capacity of 120.*

do is to satisfy the clinical staff in the matter of routine tests and to focus his attention upon one or another of the problems that present themselves to him.

The planning of a laboratory is less well standardized than that of toilet facilities or heating arrangements. This is not to be wondered at when it is considered that each pathologist has different ideas regarding the use to which the building is to be put. Nevertheless, a certain amount of standardization is necessary if work is to be done efficiently. Close proximity to the source of material is highly desirable, not only on account of the steps saved but also because of the freedom of interchange of ideas between the clinician and the pathologist.

#### *Planning and Equipping the Laboratory*

The ideal location for the laboratory is close to or in the building where the largest numbers of sick patients are found. The actual planning of the laboratory involves too many factors to be considered here. It might be emphasized, however, that the laboratory should be easy to clean, and should have a sufficient number of outlets for gas, water and electricity. The equipment offers a wide range of choice, and the director is often faced with an important problem in trying to select from the increasingly numerous appliances those best

fitted for his use. In addition to the budget for supplies there should be one for the purchase of new apparatus.

The organization of the laboratory staff depends upon the number of persons available for the work and the amount of work required. The state hospital is in a fortunate position as far as a laboratory is concerned, since the patients can carry out a good deal of the menial work and some of the simpler routine and typing. Patients should be usefully employed whenever possible. It is poor economy to have skilled technicians washing glassware, filing slides and copying reports, and a diener can usually direct two or three patients in cleaning operations and other maintenance work. I have found a dictating machine of great service and economy in the preparation of laboratory reports.

The pathologist is usually supplied with trained technicians, but he may find it necessary to instruct them in certain details and in new methods. This work is tedious but the results justify it. If he is fortunate in having a number of expert workers he will find that he can turn the work over to them and devote his energies to special investigations, teaching, clinicopathologic correlation, and even individual work in the wards. The closer contact he maintains with the clinicians, the more valuable he will make his laboratory.

In many instances the pathologist will be called upon by his colleagues to explain various peculiar phenomena observed in the patients during life, and he will find himself handicapped unless he knows a good deal about the anatomy and pathology of the brain. It has been said that the pathologist knows everything about all the diseases of all the organs—except the most important one. Most pathologists have neglected the study of the nervous system. In a number of hospitals the combination of pathologist with neurologist has been fruitful. This acts in a number of ways to bind the clinical and laboratory staffs more closely together, and trains the individual in a more careful examination of patients both before and after death.

#### *Possibilities the State Hospital Offers*

Most pathologists in state hospitals will find their time largely taken up with routine examinations and will bewail their inability to devote themselves to problems of their own choosing. It lies in the individual, however, to find problems to his own liking in the material presented to him. Experimental work is not encouraged in hospitals whose budgets are limited largely to the actual care of patients, and experiments have necessarily been restricted to institutes devoted to this purpose. Nevertheless there are boundless possibilities of investigation open to the pathologist in a state

hospital. They will usually require adaptation of the individual, and the results will accumulate slowly, but nevertheless surely.

A certain amount of research and teaching in the hospital is almost necessary if the patients are to have the best care. Only in this way can the staff members be stimulated to increase their efficiency, try out new methods, keep up to date in their reading and transmit their enthusiasm to the patients under their care. It cannot be said too often that the shortsighted policy of turning hospitals into custodial institutions defeats its own end, in that it permits patients to accumulate in increasing numbers without the balancing factor of a good discharge ratio. Teaching and research keep the staff constantly and keenly interested in the problems before them and supply the extra force that might make all the difference between regression and recovery in certain patients whose mental abnormality lies close to the borderline of benign and malignant.

#### *How the Laboratory Can Serve the Staff*

The laboratory can serve the clinical staff in many ways, and the pathologist himself can do much in the way of offering facilities for investigation, instructing the younger staff members, providing well elaborated material at clinicopathologic conferences, discussing cases with the psychiatric staff and thus fostering the spirit of



*A view of the histologic laboratory. It will be noted that a dictating machine is attached to the microscope, a measure that facilitates histologic description.*





bination with a dictating machine. Recently service in the laboratory has been required of the medical interns, and students have been encouraged to work in the laboratory during vacation.

The yearly work of the laboratory is given in the accompanying table.

The laboratory can be of greatest value to a state hospital if its staff forgoes "splendid isolation" and participates actively in other functions of the hospital. Authorities might well bear this principle in mind in choosing employees. The laboratory budget will then not appear so high, considering the services rendered.

The laboratory of a state hospital offers a fine opportunity for the specializing neurologist who can take advantage of both clinical and laboratory facilities to extend and control his knowledge of the specialty.

The staff must be adequate to handle the situation and must not be tied down with routine tests. Teaching and research are essential for the best care of the patients themselves.

## Oversupply Problem Up to Nurses Says Doctor Burgess

Nine months of work in the year—that is the most a nurse can hope for in the United States today. The average nurse will not actually get that much.

Exact figures on the oversupply of nurses in this country were made public at San Antonio, Texas, April 12, when Dr. May Ayres Burgess, director, the Committee on the Grading of Nursing Schools, told 4,000 members of the already agitated nursing profession that no more than 273 days of work in the year are available for the average nurse. Doctor Burgess spoke before a session of the biennial convention of the three national nursing organizations, the general topic being "Nursing at the Crossroads."

This nine months of work for each nurse would be possible only if nurses served all the sick Negroes in the South and if all the very poor and all the sick in remote rural districts were adequately nursed during severe illness. Moreover, this 273 days' employment would actually be available only if sickness were spread out evenly throughout the year and divided evenly among all nurses.

"This year 25,000 young women for whom there is no work will be graduated from the nurses' training schools," Doctor Burgess declared. "Next year there will be another 25,000, and the year after that still another. In the ten years from 1920 to 1930, the population of the entire United States has increased 16 per cent, but the number of grad-

uate nurses has increased 97 per cent. The United States Census gives a total for 1930 of 294,268 trained nurses."

Doctor Burgess believes that the only way out is for the nurses to go into partnership with the public. Closing hospital training schools for nurses will not come as a purely voluntary measure. Superintendents of hospitals and superintendents of nurses sincerely believe that their schools are better than others and that their graduates are needed in increasing numbers, even though there is unemployment among their alumnae at the present time.

She outlined four tasks for the nurses in securing a working partnership with the public. They are as follows: (1) to give full publicity to the facts about the overproduction of nurses and the necessity for choosing new students with the utmost care; (2) to obtain close personal contact with influential citizens, so that those who shape public opinion may become interested and informed concerning nursing problems; (3) to be on the alert through local nursing organizations to work with the public on the side of desirable public health movements, so that community leaders will learn to look to the nursing organizations for co-operation; (4) to wage an effective campaign against any attempt to continue or increase the overproduction of nurses in that community.

## How the Drive Against Cancer Is Progressing

The efficacy of the drive against cancer in Massachusetts has been emphasized recently through clinics for physicians at which "cured" patients were presented. These patients, who have not had any return of cancer symptoms for a specified period, were those who sought early diagnosis and were given prompt treatment. The patients are graduates of state aided and other recognized cancer clinics. The campaign in Massachusetts was sponsored by the Massachusetts Department of Public Health, the Massachusetts branch of the American Society for the Control of Cancer and the cancer committees of the Boston Health League and the Massachusetts Medical Society.

New clinics reported include a tumor clinic at the University of Chicago and a diagnostic cancer clinic at the new Norton Memorial Infirmary, Louisville, Ky. The medical society of Hillsborough County, Florida, has recently approved a plan for operating a cancer clinic under the auspices of the society for which funds have been offered from outside sources.

# How the Record Librarian Serves Three Masters Impartially

By GRACE WHITING MYERS

President, Massachusetts State Association of Record Librarians

ONE of the main objects of all organizations of record librarians (and there are now many) is that they shall play their part in the hospital field with efficiency and in a spirit of cooperation. I shall discuss briefly from the record librarian's standpoint the relation she bears to the superintendent of her hospital, to the hospital itself and to the community in the midst of which her hospital stands.

First, what is her relation to the superintendent of her hospital? Between these two there is a double relation—one of responsibility on the part of the record librarian to the superintendent, and the other of dependence on the part of the superintendent upon the record librarian.

All departments of hospital activity are directly responsible to the head of the institution. The chief of the record department, by whatever title she may be called, should in this day and generation be a trained worker, one who is keenly alive to her responsibilities; for the record room is a center of information regarding the most important work of the hospital. Hospitals are built for the care, treatment and cure of the sick. That is their business, just as the production of goods is the business of the factories. To report work done in so many figures is necessary. But there is another equally important report. The most vital thing is, what kind of work has been produced? What are the results—good, indifferent or bad? Hospital efficiency is measured by the end results of the work of its staff. And there can be no knowledge of end results obtained unless there is a record of beginnings and of the gradual progress toward those results. Well ordered and accurate clinical records, written day by day, show this progress. They give the real report of the work done in the hospital.

## *Recording the Institution's Progress*

To this or that institution comes the sick man to be made well, if it is possible for any human agency to make him so. If he does not recover, why is it? The clinical record, carefully and honestly written, tells the story. It is the record

librarian who, reaching out to all parts of the hospital—to the x-ray department, the laboratory, the operating room and even to the home of the patient through follow-up letters and with the aid of the social service department—gathers all the facts about every patient and makes it possible for the hospital superintendent to discover what kind of work his institution is doing. He gets this knowledge through the gathered statistics that make up the daily, weekly, monthly and annual reports of the record department.

## *A Valuable "Nuisance"*

If a record librarian is competent she keeps her finger on the pulse of the hospital staff, and if she detects any weakness in the contributions to the history of this or that case and if she has vainly done her best to relieve the condition, she reports to the superintendent asking for advice concerning further treatment. If there is lack of care in getting the important end result of a case and if she has used her best efforts to obtain it, again in vain, the superintendent should be so advised. And he should be a willing listener, for it is to his distinct advantage to be able at any time and without delay to put his hand on completed records. Some moot question in law may demand it, statistics of the prevalence of a certain disease may be requested, the life of a person may depend upon it or even the integrity of the institution may be at stake. I could quote a long list of possible circumstances in which a hospital superintendent depends upon his record librarian for immediate and reliable assistance.

What kind of a record librarian have you? Is she trained for her special work? Do you know whether she belongs to some organized group of persons from whom she may obtain help and inspiration? Do you ever consult her about the part she plays in your institution? May I seize this opportunity to urge superintendents to invite the confidence of their record librarians, to listen to their suggestions and to talk with them as they do with any other officers of the hospital. They have the efficiency of their department at heart,

as you would wish them to have. Your hospital needs first-class clinical records as much as it needs first-class accounting.

Now what of the relation of the record librarian to the hospital itself, impersonated in its complete staff? Its members, when they first come in contact with her, are inclined to look upon her as an omnipresent nuisance, something to be endured because the superintendent insists upon it, and back of him stand the trustees. She is everlastingly at their heels asking for notes to be promptly supplied on this, that or the other record; or for a signature written on an operation sheet or on some other sheet, and it simply has to be done or they will never get rid of her. It is of no use for them to pretend that they do not see her, for she will patiently haunt them until they recognize her existence.

But wait until a day comes when one of them is summoned to appear in court to give professional evidence on a case which he treated in the hospital, perhaps a year or more ago, and has forgotten all about. Where is he going to find that case? How is he going to get a copy of it? Did he make sufficiently full notes to answer the questions that are likely to be put to him? Oh, there is that record librarian! All smiles, he approaches her; and sure enough she produces the record, all complete and signed by himself. Could anybody blame her if she gave herself a little pat, and murmured to herself "I could have told him so"?

Someone else may wish to do a bit of research work on a group of cases; or it is requested that he make a report at a coming clinical meeting of an especially interesting case that appeared on his last service. Another has received a questionnaire (bothersome thing!) about the number of times a certain disease has been treated in the hospital he visits. It takes time for such things; he can't do it. Oh, yes; there is that record librarian. Her relation to the hospital staff suddenly becomes very friendly and she becomes very necessary.

#### *Her Contacts Are Extensive*

Aside from these individual relationships, remember her close departmental contacts with the laboratory, for every record in these days must contain a report of some nature from there; with the x-ray department, the social service and the various clinics, as maintained in all the larger hospitals. Even the kitchen is sometimes the field of her searchings, for if special diets are prescribed, they must be reported. She must know, day by day, what patients are to be operated upon, and never let the matter rest until she has received the signed report of such operations. She must know each day what discharged patients are expected

to report at the out-patient department, and have their house records ready to send there.

All that I have said refers as much to the out-patient record librarian as it does to the house record librarian. The former is perhaps the busier of the two, for she daily handles large numbers of records, and each night her work for that day must be completed, or she could not begin the duties tomorrow will bring.

Every hospital expects to grow, and its clinical records form an important part of its history, contributing as well to the history of medicine. Therefore, they should be good records from the very beginning.

#### *Serving the Community*

This brings me to the third part of the topic—the relation of the record librarian to the community. Calls for assistance come to the record room from many quarters, and a helping hand is willingly given. To mention a few of the allied organizations from which many of these requests come, there are other hospitals, medical schools, pension bureaus, insurance companies, the industrial accident board, workmen's compensation organizations and, by no means least, the department of public health.

What do other hospitals want? The largest and best known hospitals will always be consulted as to methods of administration, in which the care of records is included. They are teaching hospitals in much besides medicine and surgery. It is their privilege to pass on what they have gained to benefit the growing institutions.

Any teaching hospital is more or less affiliated with the medical schools in its community. The medical student gains the practical part of his education in the hospital. Among other things he learns how to write records, with occasional hints from the record librarian, a matter of importance to him in his later life.

The industrial accident board will not consider a claim until a record of the claimant's disability is in its hands. Nor will pension bureaus. No insurance company will take a risk on an applicant who has been a hospital patient without writing to the hospital to ask for points from his record.

The evolution of good standardized clinical records through the persistence of patient, interested, conscientious record librarians has brought about a close affiliation between the hospitals and local boards of health, to whom all cases of communicable disease must be regularly reported, generally through the record librarian. In the study of community health, what better source of information is there than these well kept files? In these days, persons no longer hesitate to go to the hos-



pital in case of illness; therefore its records make a good picture of the prevailing diseases in the surrounding district.

In Massachusetts, the department of public health has been for several years using hospital records from all over the state in the study of cancer. In response to a letter recently written to the state commissioner, Dr. George H. Bigelow, I received the following:

"In regard to the value of hospital clinic records to the community, I would say that we have recently reviewed such records in ninety hospitals in the state in regard to cancer, and find that the admissions are 46 per cent higher than they were five years ago. We have also reviewed them in regard to pneumonia and arthritis. They are of interest to us in venereal disease, all the communicable diseases including tuberculosis and the like. Such matters as delay between the first symptom and first visit to a doctor, further delay before hospitalization when indicated, the adequacy of care in the hospital, the average duration, an estimate of the cost to the community from the care given, an estimate as to the adequacy of follow-up and the like, make hospital clinic records invaluable to any health officer who is interested in any plan to improve service to any of the multiple diseases in which we must be interested."

Doctor Bigelow calls attention to the fact that much expense from needless readmissions would be eliminated if follow-up methods were more adequate. This is a thought well worth considering.

Certainly this gives sufficient proof that the community itself is dependent upon the records a conscientious record librarian is justified in demanding.

#### *A New and Important Profession*

The establishment of training classes for record librarians in a few of the large hospitals has brought this department of hospital service into professional light, and is an educational opportunity that is being sought with increasing frequency. The formation of the Association of Record Librarians of North America, together with the encouragement it has received from the American College of Surgeons and from the American Hospital Association, has impressed hospitals with the importance of maintaining a high standard of clinical records and of having a trained record librarian to keep up the standard.

At the last meeting of the Association of Record Librarians of North America, held in New York City last October, Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, came in bringing a message from the college. This message was a picture of a tall

tower with the face of a clock at its top, but minus the hands. Underneath was printed, "A hospital without a record room is like a clock without hands." I would add, "And a file of records without a record librarian is like a clock without a mainspring—it simply won't go."<sup>1</sup>

### Encouraging Hospital Workers to Save for the Future

Since full-time employees of Canadian government hospitals—doctors, nurses, orderlies and clerks—were a short time ago admitted to participation in a government superannuation scheme, the ideas of Dr. Ross Millar, director of medical services, Department of Pensions and National Health, Ottawa, are well worth quoting.

According to Doctor Millar:

"Any superannuation scheme should be compulsory on each member of a group of employees, even though this idea may verge on the border of paternalism and tend to stultify the individual's incentive towards saving for the future. Probably, however, this compulsory scheme would be productive of more good to the weaker members of the group than it would do harm to those who are already persuaded of the necessity for thrift and foresight.

"The advantages of insisting on the allowance of transfers from one hospital to another are so great that there is little room for argument. Any contribution made by a hospital, or other employer, toward pension benefits for any employee must be considered as remuneration for service rendered and not as a free gift or for service to be rendered in the future. The remuneration for service currently rendered is the actual cash payment received and also a certain provision for old age.

"Since a forfeiture of pension rights is largely traditional, such forfeiture should be eliminated from any scheme, no matter what the change of status or avocation of the employee might be. Any employee who has begun a system of preparedness for old age should be encouraged to carry on that system in any other sphere of activity.

"One additional benefit that might be suggested is that annuity payments begin with the onset of total and permanent disability, before the attainment of the age of sixty or sixty-five. This would be a valuable addition to the benefits and might not necessitate any large reduction in the benefits that otherwise would be available in consideration of a 10 per cent contribution."

<sup>1</sup>Read at the meeting of the New England Hospital Association, Boston.

# A Woman's Hospital Sets a New Goal in Its March of Progress

By MORITZ KAHN

Albert Kahn, Inc., Architects, Detroit

THE Woman's Hospital, Detroit, has had one of the most interesting and successful experiences of all the Detroit hospitals. It was originally known as the Woman's Hospital and Foundling's Home and was founded in 1869 by an outstanding group of public-spirited women of that day. The present name was adopted in 1927.

Its management since its inception has been marked by the same high character and ability. Starting in a small dwelling house, the work has increased so rapidly and consistently that each successive home was quickly outgrown. For twenty-two years the institution has been headed by Mrs. Frederick H. Holt, through whose untiring efforts the present high standard of excellence in service has been built up and maintained. For the

last three years the hospital has been directly in charge of Miss E. C. Waddell, resident superintendent.

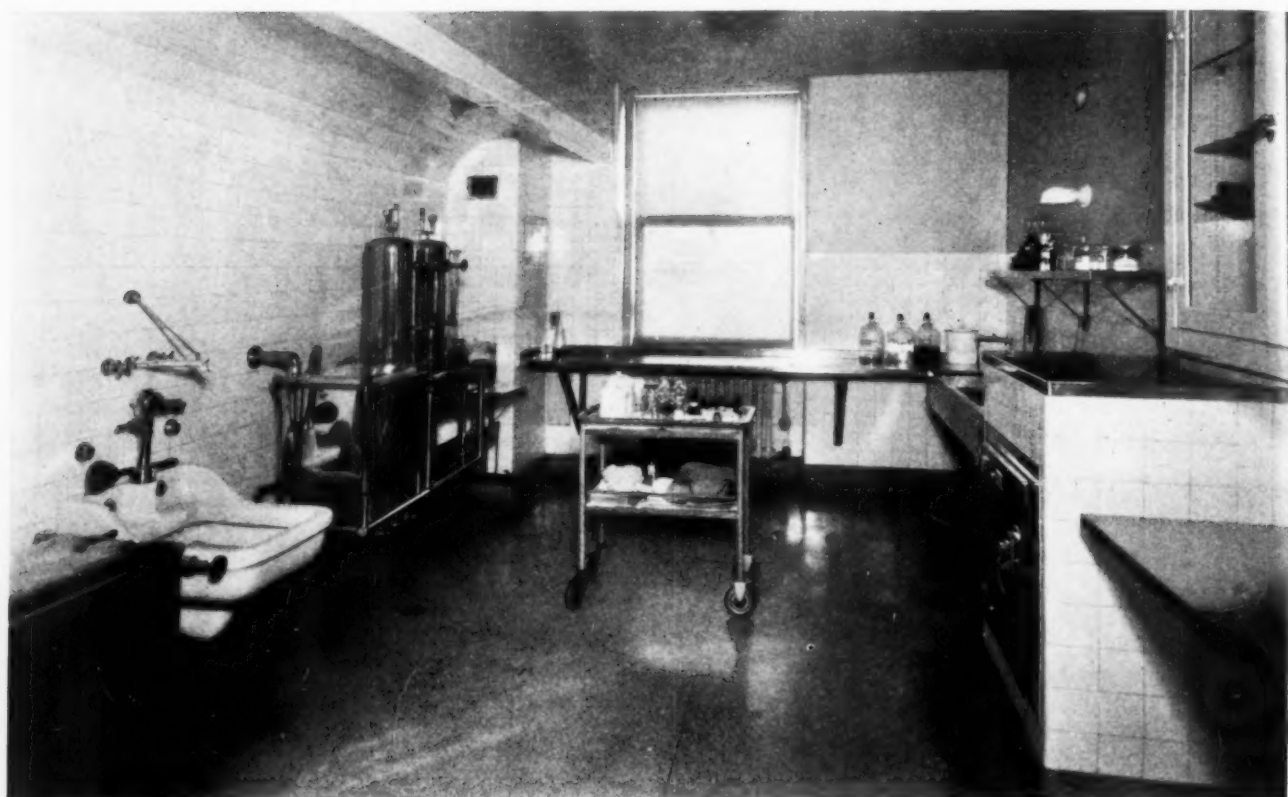
The new hospital building was completed in 1929, and thus has been occupied long enough to determine the effect of the thoughtful care given to its planning and arrangement by the architects and the building committee.

The new building occupies the north half of the block bounded by Hancock, Brush and Beaubien Streets and Forest Avenue. The south half of the property is occupied by the old hospital building, which now houses the out-patient and social service departments and the clinic, and by two other buildings used as homes for resident nurses.

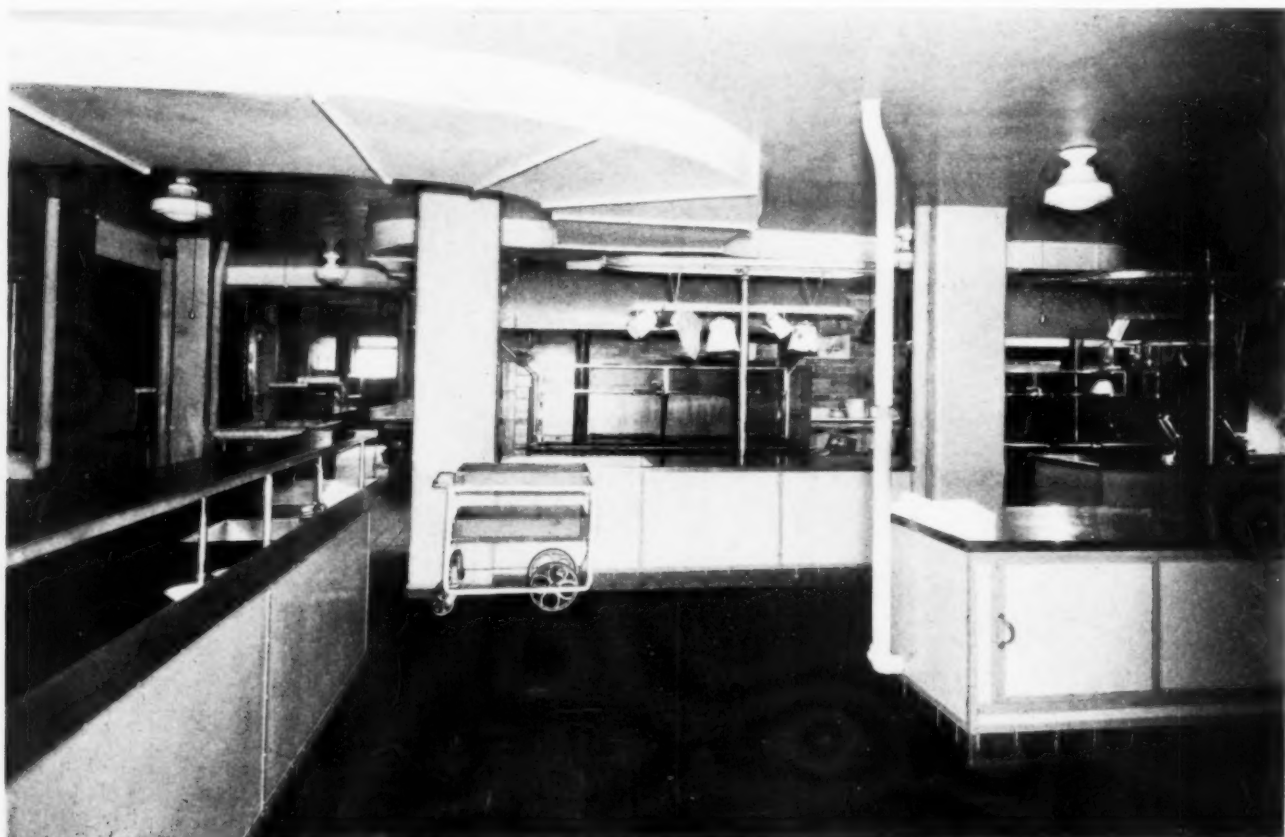
The new hospital building has been divided into



*Exterior view of the Woman's Hospital, Detroit.*



*Especial study has been given to the care and equipping of the utility rooms, one of which is shown in the upper illustration. Food service is conveniently arranged, and meals are prepared in the large main kitchen on the ground floor, pictured below, from whence trays, completely set up, are sent to the smaller distribution kitchens on the various floors.*



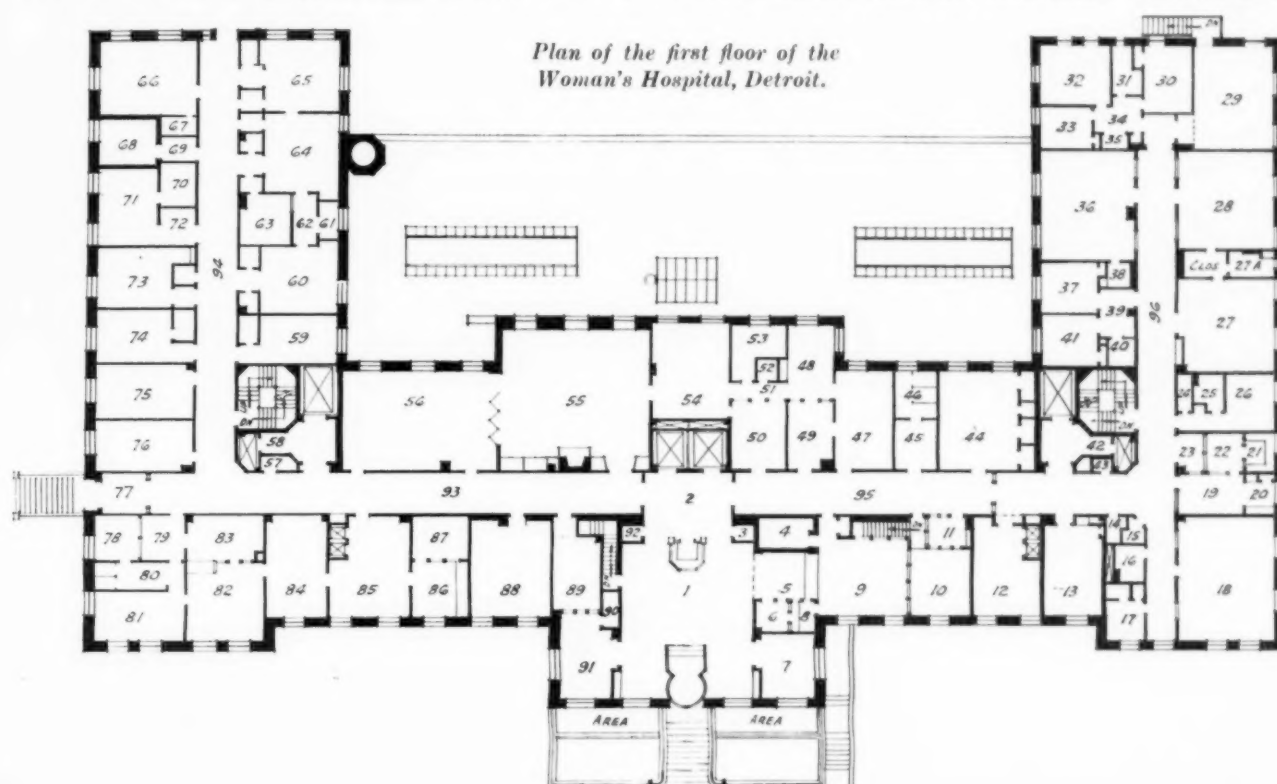


two distinct units. The general hospital and pediatric departments occupy the west wing and the maternity department occupies the east wing. The rigid requirement that these departments be kept as separate as possible has been justified by subsequent experience.

The basement or ground floor, which is not separated as are the floors above, contains the general kitchen with a separate service kitchen for each wing. Also on this floor are the dining rooms for the nurses, the employees and the staff which are served from a well equipped cafeteria; the laundry

east wing contains the x-ray department and the mother's milk bureau. This has a separate outside entrance, since these departments are frequently used by the public. On the west wing on this floor are a number of small four-bed and six-bed wards and a few private rooms.

The mother's milk bureau is worthy of special mention. The Woman's Hospital was the pioneer in developing a department where excess mother's milk could be collected and distributed for the saving of lives of premature and delicate infants whose mothers could not feed them. Careful tests



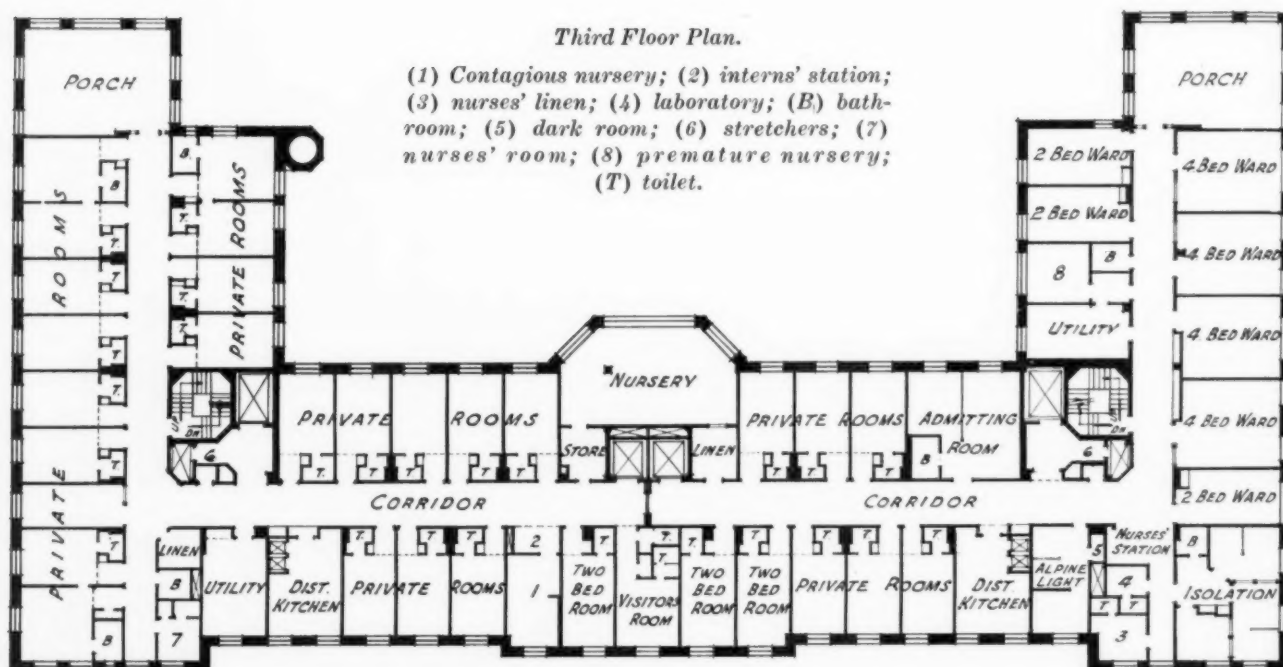
- (1) Lobby; (2) elevator lobby; (3) telephone; (4) vault; (5) admitting room; (6) public; (7) waiting room; (8) cashier; (9) bookkeepers; (10) record clerk; (11) telephone room; (12) kitchen; (13) utility room; (14) toilet; (15) linen; (16) bath; (17) nurses' room; (18) 6-bed ward; (19) nurses' station; (20) medicine; (21) laboratory; (22) intern; (23) waiting room; (24) toilet; (25) bath; (26) admitting room; (27) 4-bed ward; (27A) utility; (28) 6-bed ward; (29) porch; (30) bedroom; (31) bath; (32) living room; (33) bedroom; (34) hall; (35) closet; (36) 6-bed ward; (37) isolation bedroom; (38) utility; (39) hall; (40) bath; (41) isolation bedroom; (42) stretchers; (43) janitor's closet; (44) staff room; (45) lockers; (46) toilet; (47) superintendent of nurses; (48) stenographer; (49) instructors; (50) waiting room; (51) passage; (52) toilet; (53) rest room; (54) superintendent; (55) board room; (56) unassigned; (57) janitor's closet; (58) stretchers; (59) colored waiting room; (60) cystoscopic room; (61) transformer; (62) control room; (63) dark room; (64) plate room; (65) fluoroscopic room; (66) diagnostic room; (67) toilet; (68) storage; (69) linen; (70) transformer; (71) deep therapy; (72) control room; (73) fracture room; (74) white waiting room; (75) physiotherapy; (76) circumcision; (77) vestibule; (78) nursery; (79) waiting room; (80) rest room; (81) milk expressing; (82) pasteurizing room; (83) office; (84) bottle washing and workroom; (85) formula room; (86) milk laboratory; (87) drying room; (88) library; (89) private waiting room; (90) toilet; (91) waiting room; (92) telephone; (93) corridor; (94, 95, 96) corridors.

and linen storage rooms; the pharmacy; the general sterilizing rooms; the food storage rooms; refrigerating facilities; two lecture rooms; a training and demonstration room, and the general stores for other hospital supplies. The ambulance entrance and receiving room are also on this floor, as are the boiler and machine rooms.

On the first floor are the general lobby, the elevator hall and the offices, the directors' room, the library and the staff room, centrally placed. The

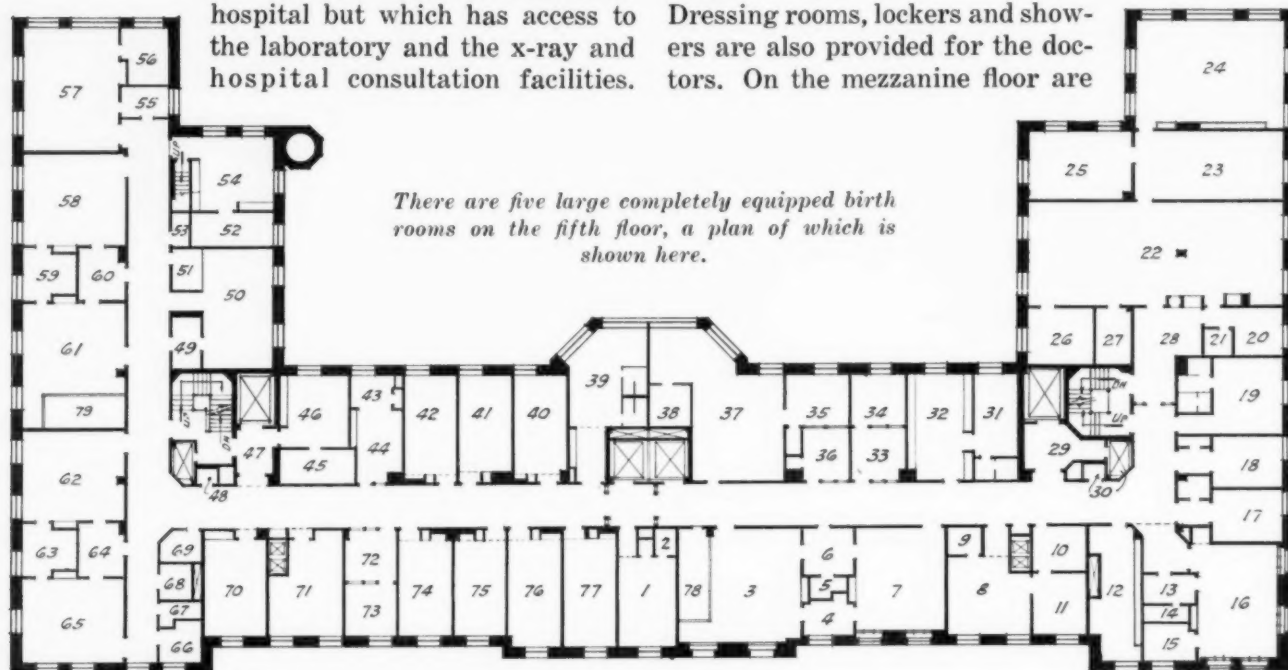
are made of all sources of supply, a precaution that has made the service of the bureau notable during the fourteen years it has been in operation.

The second, third and fourth floors are equipped with both single and double rooms and a few four-bed wards for patients. These rooms are divided between the general hospital medical and surgical work in the west wing and the maternity cases in the east wing. Four floors of the east half of the building, which are separated from the west half



of the hospital, are devoted exclusively to maternity patients and newborn infants. These floors have accommodations for ninety-seven mothers and one hundred infants. With their private elevator service, a special laundry and independent distributing kitchens, they constitute a unit which is virtually a separate maternity hospital but which has access to the laboratory and the x-ray and hospital consultation facilities.

On the fifth floor are a modern preparation room, seven labor rooms with special beds for the administration of analgesics and five large completely equipped, green tiled birth rooms. The scrub-up rooms for doctors and nurses and also a separate utility and sterilizing room are placed between each suite of rooms. Dressing rooms, lockers and showers are also provided for the doctors. On the mezzanine floor are



(1) Visitors' room; (2) toilet; (3) operating; (4) sterilizing; (5) equipment; (6) wash-up; (7) operating; (8) eye, ear, nose and throat; (9) wash-up; (10) wash-up; (11) operating; (12) instruments; (13) wash-up; (14) sterilizers; (15) sterilizing; (16) operating; (17) anesthesia; (18) recovery; (19) women doctors' locker room; (19A) toilet; (20) patient's room; (21) toilet; (22) general workroom; (23) pathologic technique and filing; (24) diagnostic library and filing; (25) research room; (26) workroom; (27) storeroom; (28) waiting room; (29) stretchers; (30) janitor's closet; (31) toilet; (32) men doctors' locker room; (33) office; (34) stenographer; (35) nurses' room; (36) supervisor; (37) workroom; (38) sterilizers; (39) preparation room; (40) labor; (41) labor; (42) labor; (43) medicine; (44) nurses' station; (45) toilet; (46) men doctors' locker room; (47) elevator lobby; (48) janitor's closet; (49) instruments; (50) workroom; (51) sterilizers; (52) toilet; (53) closet; (54) women doctors' locker room; (55) wash-up; (56) sterilizing; (57) septic delivery; (58) delivery; (59) sterilizing; (60) wash-up; (61) delivery; (62) delivery; (63) sterilizing; (64) wash-up; (65) delivery; (66) laboratory; (67) toilet; (68) linen; (69) stretchers; (70) utility; (71) kitchen; (72) office; (73) stenographer; (74) labor; (75) labor; (76) labor; (77) labor; (78) seats; (79) seats.

sleeping rooms, dressing rooms and showers for doctors who find it necessary to stay overnight. A similar unit is provided for women doctors. There is also a waiting room at the end of this unit for relatives of patients.

There is a special unit on the second floor for the care of patients requiring isolation. This includes a birth room, a utility room and three private rooms.

On each of the three floors is a large, light nursery with windows of ultraviolet ray transmitting glass. These windows face south. A spe-

ment of diseases of children. In addition to the usual standard equipment, apparatus is installed for the electrocardiographic examination of heart cases and for the determination of the basal metabolism rate. There are also other modern diagnostic devices. An oxygen tent has been installed to care for certain types of respiratory conditions. A battery of ultraviolet lights is placed in especially designed treatment rooms, and provisions are made for the treatment of patients by physiotherapy. The diet kitchen and formula rooms incorporate the latest improvements in the



*The cheerful airy sun parlor for pediatric patients has been attractively decorated with colored murals depicting nursery tales.*

cial nursery for the care of premature infants is on the fourth floor. The nurseries are equipped with individual bassinets. Every modern provision, including thermostatically controlled water heaters, is made for the care of the newborn.

In plan and in equipment to promote the safety and well-being of mothers and infants the obstetrical department is complete.

The west wing provides forty beds for general hospital cases, in addition to other special work.

Especially worthy of note is the department of pediatrics on the third floor in this wing. This department consists of thirty-nine beds and is thoroughly equipped for the diagnosis and treat-

construction and arrangement of such departments. There is also a room on the pediatric floor for the care of premature babies not born in the hospital. This room is equipped with automatic heat regulation.

Provisions are made for isolation of all the ward patients prior to their admission to open wards. There is a series of specially arranged cubicles in which newly admitted patients can be separated, not only from each other, but from children already in the hospital, until cultures have been taken, general examinations made and infections detected. These precautions are taken to prevent the introduction of communicable diseases into the



hospital. In addition to this admittance isolation suite, there is also a completely isolated suite of cubicles for the segregation of children who develop suspicious symptoms while they are in the hospital. This isolation suite is a complete unit, requiring separate and distinct service, including nursing.

The private rooms are unusually large and will admit two beds for two members of one family, if necessary. Each private room has separate toilet and service facilities.

In addition to the main laboratory on the fifth floor, there is a small laboratory on the pediatric floor for the immediate inspection of laboratory material during the attending physician's visit. The general layout permits both corridors to be observed from the nurses' station. All cubicle partitions are of glass, permitting the ready observation of all isolation rooms.

The entire portion of the hospital devoted to children is glazed with an ultraviolet ray transmitting glass which ensures a maximum of active sunlight at all times. In addition, there is a roof garden reached by elevator. The cheerful airy sun parlor on this floor has been attractively decorated with brightly colored murals depicting nursery tales.

The gynecologic and surgical operating rooms are on the fifth floor in the west wing where there are three operating rooms with anesthetizing rooms. The operating rooms have a northern exposure and are faced with soft green tiling. These rooms are of excellent size, special emphasis having been laid on the desirability of greater air space in the operating rooms than is usually found in hospitals. Greater comfort is assured to doctors and nurses and as a consequence greater safety to the patient. These rooms are of modern design and equipment. Each room is supplied with up-to-date operating room lights. X-ray apparatus is connected with the rooms so that operations may be more readily performed with its aid.

#### *Facilitating Proper Asepsis*

Adjoining each operating room is a scrub-up room for surgeons and one for nurses, in addition to a convenient utility and sterilizing room. To facilitate proper asepsis, careful attention has been given to the equipment of these rooms. Well lighted and well ventilated dressing rooms for the surgeons are directly opposite the operating rooms. These are equipped with individual lockers and showers.

The operating rooms of the ear, nose, throat and eye department are two in number, one of which has been designed for ear, nose and throat operations exclusively. The other is used for eye opera-

tions. Careful attention has been given to the equipment and lighting of this suite.

The general laboratory, which is also on the fifth floor in the west wing, in convenient proximity to the general operating rooms, is large, unusually well lighted and divided to afford the best physical facilities for all divisions of hospital laboratory work. The large general workroom is well lighted on both sides of the room and is provided with an adequate fume closet. Two rooms are provided for research work or for other work requiring isolation. In one large and attractive room at the extreme south end are an adequate working library and the display specimens that are of practical value in daily routine work.

Among many interesting features with which this most modern hospital is provided may be mentioned an outdoor roof garden. Provision is also made for radio receptions in all private and two-bed rooms.

#### *How Food Service Is Arranged*

Food service is conveniently arranged. Meals are prepared in large preparation kitchens on the ground floor, from whence the trays, completely set up, are sent in quantity to the smaller distributing kitchens on the various floors. By this system much saving of effort is effected and meals reach the patient promptly and in good condition.

Especial study has been given to the planning and equipment of the utility rooms.

So great has been the growth of the hospital service since the new building was erected that plans have already been prepared for a large addition, the construction of which is waiting favorable economic conditions. This addition will house the clinic and the social service departments and will also provide quarters for the present hospital employees and nurses. There will be one floor devoted to rooms and wards for patients. In addition, a further extension is proposed to be used entirely for a nurses' home. In the planning of this building every effort has been made to create insofar as possible, a complete self-sustaining hospital institution.

Planning a hospital is not essentially different from planning a building for any productive industry. Patients are received, treated, made well and returned to their homes. The marked difference from the usual productive process is in the character of the treatment. Human bodies and personalities are treated, instead of inert materials; hence, the attention that must be given to details ensuring the comfort of the patient.

The satisfactory results achieved in the planning of this hospital have proved gratifying to both the administration and the architect.

# The Dietitian—Her Past, Present and Future

By C. J. DECKER

Superintendent, Toronto General Hospital, Toronto

**M**Y EXPERIENCES with dietitians and with hospitals date back some sixteen years and began first as a result of my association with a research bureau.

I was assigned to make a survey of a hospital of approximately 300 beds, situated in an important metropolis of a Southern state. I spent some five weeks in that hospital studying the various phases of operation and the relative efficiency of the several hospital departments.

In the course of my duties I had occasion to confer with the dietitian upon matters concerning the food service in general, and her work in particular. I endeavored in every way possible to find out from her exactly why she was there and what her responsibilities were. I would remind you that at the time I knew nothing of the dietitian and little more about the hospital, and I tried earnestly to learn what a dietitian was and what she was supposed to do. This particular dietitian informed me that her duties were to draw up menus for the patients and the employees of the hospital, menus that would satisfy, as far as possible, the appetites of those who were to receive them. She told me that this was often difficult as the purchasing agent would not always buy the supplies that she wanted and that were necessary in order to please everyone. It was also her duty to supervise the kitchen staff. Here her responsibilities ended.

## *The First Impression*

In the report of my findings submitted to the board of trustees of that hospital, I had the following to say concerning the dietitian: "The hospital food service is, on the whole, good but altogether too costly. The dietitian seems to be the cause of much extravagance; indeed her services might well be terminated without adversely affecting the efficiency of the department. She is an encumbrance to the kitchen staff with whom she is constantly at variance." The trustees of that hospital were entirely in accord with my views as relating to the dietitian's services and she was promptly dismissed; nor was another dietitian engaged for nearly two years.

This was my first impression of the dietitian. I believed, as did many others of the laity at the time, that the sole duty and object of the dietitian was to suggest menus of good variety designed to tempt the appetite, whether or not they were well balanced.

A year or so later I was called to Toronto to make a similar study of the Toronto General Hospital. Fortunately, I had learned a little more about the dietitian and what should be expected of her, and when my report was submitted to the trustees of this hospital I refrained, at least, from saying that they might dispense with her services.

This was the dietitian of the past.

## *Ever Increasing Responsibilities*

The dietitian of today holds a truly important place in the everyday life of the modern hospital. Indeed she is no longer confined to hospital walls but has creditably carried her professional services to hotels, clubs, schools and to many industries of the present day. Her contribution to the better treatment of patients in hospitals is admittedly an important one. She is an integral part of all large food services. Her duties not only include the supervision of quantitative and metabolic diets for those who require them, and the well balanced full diet for the various staffs of the hospital, but all of these, with an economic balance of her menus.

I wonder to what extent the present status of the dietitian is due to her own efforts, her own aggressiveness and her own initiative. Has she not attained this higher plane to which she has been elevated because of the potential need of a service which finds its answer in the field of her endeavor? To what extent has the standard of the present day dietitian been forced upon her by the medical profession, by the hospital, by commerce and by the public at large? It is not many years since the medical profession began to realize the important part that proper nutrition and the elimination of certain detrimental elements of diet play in the treatment of many serious ailments.

The profession demanded of hospital authorities a medium through which it might work out these

problems. With the advent of insulin the issue between the profession and the hospital was, so far as many hospitals were concerned, brought to a point where it could not longer be evaded. Hospitals everywhere began to search the field for dietitians qualified to handle the situation. Let me say here that ten or twelve years ago dietitians of this type were not easily found. As a result of this new demand for well trained dietitians, domestic science schools, universities and hospitals took cognizance of the situation and began to reconstruct their curricula and to plan the courses of training that should be offered to dietitians of the future. Those responsible for commercial food service saw the dietitian in a different light, and today we find few services that do not include one or more dietitians on their staff.

Governments, municipal, state and federal, find that they too have need of the sciences of food available to them in the well trained dietitian.

#### *Joining Forces With Medicine*

To the dietitians engaged in commerce—I refer to those associated with hotels, large restaurants, clubs and schools—in fact, to all those who are engaged in the daily routine preparation of menus, variety in foods alone is not in itself sufficient to satisfy, over a long period of time, the people whom they are serving. For example, someone tells us of a good place to eat. We try it, we like it and we go back again with our friends. We go frequently, but somehow or other the food does not taste quite the same and we decide to make a change. We may go back to an old stand and, after partaking of a few meals, we wonder why we ever left it. It is not long, however, before we again notice a waning appetite which is not revived until we make another change. Now why is it? We have had variety a-plenty and yet there is a certain sameness about it that becomes monotonous.

This is true in our experience with nurses. The chef in the kitchen can always tell when a new class of nurses has been admitted. New nurses—excuse the saying—"eat like a house afire," but after they have been in the hospital for a matter of a few months they become solid converts to the oppositionists—nothing tastes the same any more. This is one of the dietitian's problems, an important one, and one for which there is undoubtedly a remedy. I wonder whether the seasoning, the shortening and the constant adherence to particular brands of staple articles such as flour, corn starch and sugar that are embodied in the preparation of foods, are not, in part, responsible for it.

The dietitian may, I think, view the progress of the past ten years with almost entire satisfaction for she has made important strides in the interest

of her profession in general. Gratifying as these achievements must be to her, her responsibility has increased manyfold. The dietitian in hospital work is entrusted with a phase of treatment of the patients who come under her care, which is often of greater importance than that of the nurse who is relied upon to give medicines and carry out the treatment as prescribed by the attending physician. So important is her work that often human lives depend upon it. The medical profession depends upon her special knowledge and skill to work out for them the diet and quantities calculated to give desired results. Upon her efficiency and conscientiousness rests the success of the treatment. The dietitian must accept these responsibilities seriously.

As medicine and its allied sciences are constantly reaching out in search of new discoveries, new methods of treatment and new cures, so must the dietitian keep abreast of the times.

This is an age of prevention and eighteen-day diets. Many absurd plans are being offered to the public, plans designed to accomplish but one end, regardless of the dangers to health and life. In the past the dietitian has been far too modest in asserting her proper position, not only in the economic but in the physical life of today. Who should be better qualified to prescribe diets? It seems to me most reasonable that what we take into our bodies to sustain and to nourish us must be responsible for our health as we enjoy it and that poorly balanced diets must account for much of the ill health that humanity has known in the past and suffers today. I do not for a moment suggest that the dietitian should undertake to diagnose and treat bodily ailments—this is a matter for the medical profession with which she is closely allied—but I do consider it entirely within the province of the dietitian to endeavor to make us a better informed public where the important subject of nutrition is concerned.<sup>1</sup>

### **New Veterans' Hospital Will Be Built at Batavia, N. Y.**

President Hoover has approved Batavia, N. Y., as the site for the new veterans' hospital in western New York, the Veterans' Administration announced recently.

The Federal Board of Hospitalization recommended Batavia to the President because it was situated so as to serve veterans in western New York and because a building site was offered to the Government without charge, according to information made available at the administration.

<sup>1</sup>Read at the meeting of the Ontario Dietetic Association.



# A Laundry Plant That Was Built Practically Overnight

By W. R. CHENOWETH

Superintendent, Royal Victoria Hospital, Montreal

**W**HAT is decidedly an achievement in building is the laundry plant of the Royal Victoria Hospital, Montreal. The building was started in May, 1931, and was completed and in use by the end of June.

The laundry is built on the site of and has incorporated in it the existing ambulance garage, the carpentry shop and the paint shop, and is situated on the west side of the upper or north end of University Street, which forms the eastern boundary of the group of buildings that make up the hospital.

All portions of the building incorporated in the new laundry building which were not of fire resis-

tive construction, were removed and the whole of the completed building is now constructed of reinforced concrete floors and columns, with masonry walls.

## *Details of Construction*

The old buildings which formed the base of the new laundry floor had concrete walls, and the walls of the ambulance garage were faced with random ashlar gray limestone. These have now been incorporated in the walls of the completed building. The new walls for enclosing the new laundry floor were built of brick, and these, together with the old concrete walls, are finished with gray limestone



*The laundry, Royal Victoria Hospital, Montreal, is conveniently near the main hospital buildings.*



*The laundry room, pictured above, has red quarry tile floors, tile walls and an enameled ceiling. Most of the heavier machinery is installed here. The ironing room, illustrated below, is equipped with air presses, ironing boards and a collar machine.*



trimmings and gray waterproof cement stucco to harmonize with the stonework.

The windows of the laundry are double hung steel windows and are fitted with bronze wire fly screens throughout.

The roof is flat and is weatherproofed with tar and gravel roofing and copper flashings.

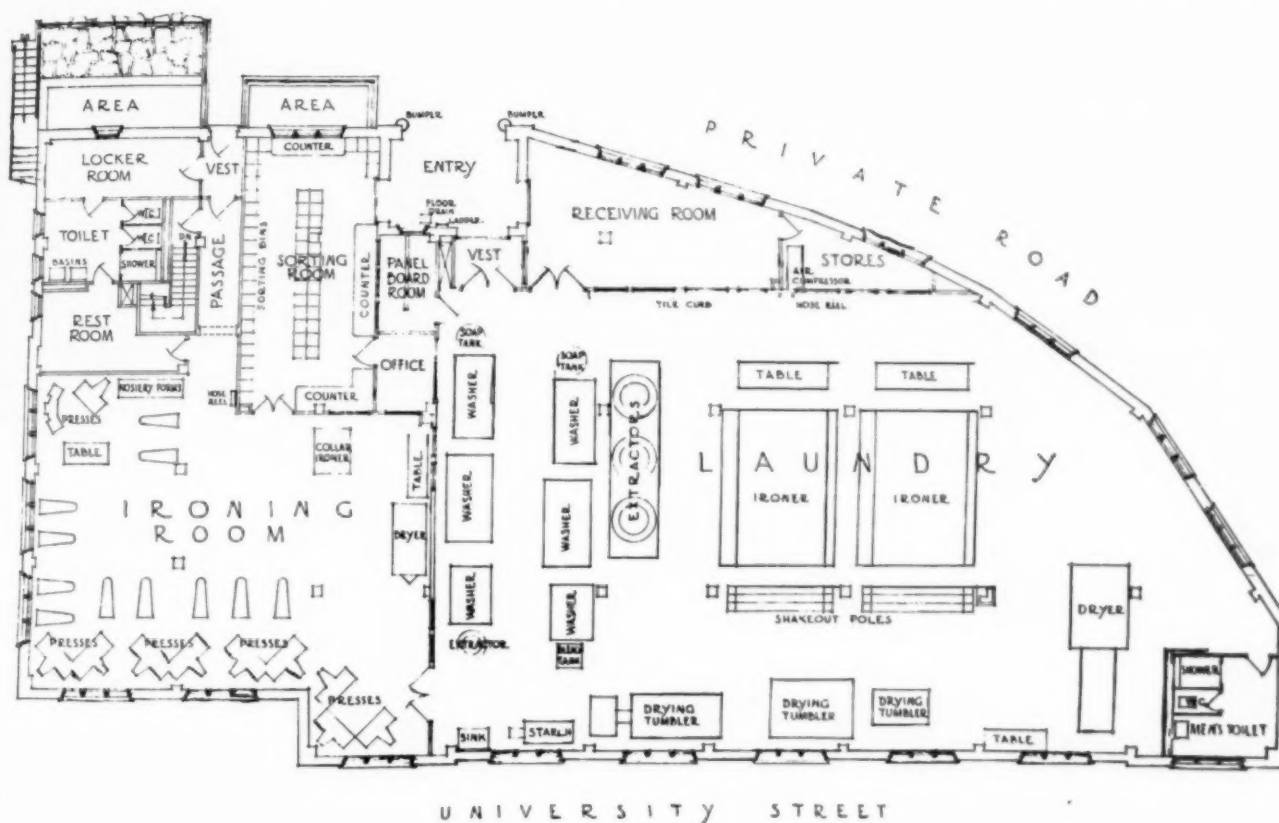
The building is three stories high and is irregular in shape. It is approximately 73 feet wide and 145 feet long.

The lowest floor contains the ambulance garage, the carpentry shop, the paint shop and a parking

rooms are finished with red quarry tile flooring, white tile walls and an enameled ceiling. The receiving room and the sorting room are finished with cement floors. The toilets are similar to those on the floor below.

#### *How Steam and Heat Are Supplied*

The laundry is supplied with high pressure steam from the central heating plant of the hospital building. The laundry building is heated by low pressure steam, thermostatically controlled, taken from this main through a reducing valve.



PLAN OF LAUNDRY FLOOR

garage at the north end. An intermediate floor at the south end provides living quarters for the ambulance chauffeurs and for the laundry matron. The rooms in this portion are generally finished with linoleum flooring, a cement base, painted, and plastered walls and ceiling, which are also painted. The washroom and bathroom are finished with tile floors and dadoes with a marble shower compartment. The toilet partitions are metal and the walls and ceiling are finished in enamel.

The top floor contains the laundry quarters. These consist of a receiving room, a laundry room, an ironing room, a sorting room, a locker room, a rest room and toilets. The laundry and ironing

A gravity ventilating system is provided for the garage, the toilets and the bathrooms. The laundry and ironing rooms are provided with power ventilation that consists of ventilation hoods in the roof equipped with motor driven fans and air operated louvers, all arranged with a control from the laundry room floor.

#### *Electric Panel Controls Machinery*

To provide a maximum of safety and economy of maintenance, the automatic electric panel which controls the several laundry machines has been installed in a room used exclusively for this purpose.

Lighting and power service is provided from the



central plant of the hospital buildings. The lighting installation has been designed to meet the particular requirements of the laundry and ironing room, a feature being the use of special diffusers.

The laundry is equipped with 5 washing machines; 2 eight-roll mangles; 4 extractors; 2 drier tumblers; 13 air presses; 1 collar machine; 1 shaker; 13 ironing boards; 1 sectional drying room; 1 75-gallon starch cooker; 2 soap tanks; 40 trucks; 36 laundry baskets, and 48 laundry bags.

The laundry handles approximately 600,000 pieces a month and the transfer from the old laundry to the new was made without any interruption in service to the hospital. The transfer was partly facilitated by the installation of one new eight-roll mangle, three extractors and one drier. These were installed as the building progressed.

The personnel of the laundry is composed of one woman supervisor, one assistant, eight men and twenty-six women, a total of thirty-six. The pay roll aggregates \$19,000 a year.

## Changing Trends in Out-Patient Department Work

In a study of the economic status of those applying for treatment in its clinics, the New York Post-Graduate Medical School and Hospital, New York City, finds 12½ per cent of its patients coming from families in which no member is gainfully employed, according to Dr. John P. Ruppe, superintendent of the out-patient service.

Addressing members of the Hospital Association of the State of New York at their annual conference, Doctor Ruppe said that \$25 a week was found to be the average family income of patients attending the Post-Graduate dispensary, and the average family rental paid was \$32 a month.

The study was made in order to ensure the hospital against the misuse of its funds for the free care of the really deserving poor at a time when the demands were many and urgent, and to refute frequent criticism by the practitioners of the city that the larger dispensaries were treating, practically without charge, patients well able to pay the fees of a private physician. According to Doctor Ruppe, the findings would seem to belie such a condition at the New York Post-Graduate Hospital which operates one of the largest out-patient services of any private hospital in the city.

"By such careful examination of the economic status of the patient of today," said Doctor Ruppe, "it is found that many who could formerly meet a physician's fee are no longer able to do so and are now compelled to utilize clinic service. By the same

token, many who could formerly just meet the moderate clinic charges are today entirely without funds and must avail themselves of free clinic service, such as can be found in state or municipally controlled institutions."

The following maximum income scale used as the basis for clinic eligibility at the New York Post-Graduate Hospital, is derived from the minimum of that scheduled by the Cornell Pay Clinic:

Single individual	weekly income	\$21.15
Family of two	weekly income	30.77
Family of three	weekly income	35.58
Family of four	weekly income	39.42
Family of five	weekly income	42.31

The majority of clinic patients fall well within the schedule, Doctor Ruppe explained, and when patients apply whose resources preclude their deserving clinic treatment, they are referred to their own private physicians or to those on the hospital staff. On the other hand, for the patient desiring to maintain his independence, yet manifestly unable to meet even the small fees for admission, x-rays and laboratory tests, the "part payment plan" has been devised and is in use in many of the larger hospitals. This deferred payment, or "health on the installment plan" idea is one of the ways in which the out-patient services are helping to meet the economic problems of their patients and has been in effect for eighteen months or more in many of the larger hospitals, with considerable success to both hospital and patient. The Post-Graduate Hospital reports approximately 40 per cent collection on these deferred payments.

## The Fundamentals of a Hospital Record System

A valuable booklet on "The Fundamentals of a System of Hospital Records" has recently been issued by the Physicians' Record Company, Chicago. It is priced at fifty cents.

The booklet describes the basic features of obtaining, filing, indexing and preserving the essential medical records of the hospital. It is plentifully illustrated with reproductions of the various forms required and with photographs of approved filing cabinets. A layout of a well planned records office is presented as is also a plan of a record storage room.

Discussed in order are: starting the patient's record; filing the hospital records; the cross-index by diseases and operations; records for the laboratories; physicians' index and staff records; monthly statistical reports.

# Making Surgery Available to the Sanatorium Patient

By EDWARD S. WELLES, M.D.

Saranac Lake, N. Y.

**S**URGERY in the treatment of pulmonary tuberculosis has definitely established itself. Whole sessions of national societies are devoted to discussions of it, and whole books have been written on the subject.

Just as artificial pneumothorax was rationally resorted to to provide a further degree of rest to the lung that was not healing through the simple diminution in respiration provided by bed treatment, so other mechanical aids to rest were called in. Extrapleural thoracoplasty was developed by the Germans for cases in which the disease was largely confined to one lung and in which pneumothorax was impossible on account of pleural adhesions. This operation, which was once considered a desperate step to be used only as a last resort in far advanced cases, is now in the hands of skilled thoracic surgeons a safe procedure with a mortality rate much lower than that of many of the readily accepted abdominal operations. In two-thirds of the cases good results are obtained. Half of these patients are clinically cured so that they can return to their homes and resume normal living.

These figures are based upon reports of large numbers of operations taken from the combined statistics of clinics all over the world. When the fact is taken into consideration that these patients are all in advanced stages of the disease and all other measures have been tried and failed, the results are more than gratifying.

## *Good Results Obtained With Phrenicectomy*

More recently the operation known as phrenicectomy or exeresis of the phrenic nerve has come into general use. This is a minor procedure done easily under local anesthesia in a few minutes and giving no shock to the patient. The result is paralysis of the diaphragm on the affected side. The beneficial effects are twofold: There is some direct compression upward from the rise of the diaphragm into the chest and a general relaxation of the lung which is not expanded downward with each inspiration. Results are often striking. Thin walled cavities in either the base or the apex of

the lung may close promptly and fibrosis may proceed rapidly to complete arrest of the disease. In other cases no benefit results and other measures must be resorted to. In spite of what some authors have said about the possibility of serious harmful results occurring in occasional cases my associates and I at Saranac Lake consider the operation a safe one and in a series of about nine hundred cases have seen really deleterious effects in less than 1 per cent.

## *The Introduction of Cautery Pneumolysis*

A third and somewhat newer surgical measure is cautery pneumolysis or the cutting of adhesions in the pleural cavity in cases of artificial pneumothorax in which the lung is partly held out to the chest wall. This operation was introduced by Doctor Jacobaeus of Sweden and brought to general acceptance in this country by the excellent work of the Doctors Matson of Portland, Ore.

An instrument called a thoracoscope, similar in appearance and construction to a cystoscope, is introduced through a trocar between the ribs. The whole inside of the pleural cavity is easily visualized and the adhesions are seen. A slender cautery or a high frequency needle is introduced and the adhesion coagulated and burned through. When the procedure is properly done bleeding rarely occurs and if it does it can be quickly and easily controlled. By this method complete collapse of the lung can usually be obtained and in cases in which pneumothorax has been unsatisfactory and open cavities exist the results can be converted into successful ones. Fluid is a sequela arising in a fair number of cases following the operation, but it is rarely a serious complication. Real empyema can result from the cutting through of diseased tissue containing organisms, but this has been so rare in my own series of some hundred and fifty cases as to be inconsiderable.

It is easy to describe the surgical operations. As I said in the beginning, they are all thoroughly established procedures in the modern treatment of pulmonary tuberculosis. To what extent, then, should surgery be provided in tuberculosis sana-

toriums? To my mind there can be but one answer. All of these surgical aids in treatment should be available to all patients. The sanatorium that is not able to give its patients the benefits of every form of modern treatment is not serving its purpose adequately and is not doing its full duty to the community it serves. Certainly all will agree that a sanatorium that does not make use of artificial pneumothorax is not a satisfactory one to which to refer patients. The same is true of surgery. Some patients with tuberculosis will recover on simple bed rest. Others must have pneumothorax and others will get well only if given the help the surgeon can offer.

#### *Training Tuberculosis Surgeons*

A much more difficult question to answer is how is surgery to be made available to all tuberculosis sanatoriums? One solution that has been offered is to train some member of the staff of each institution to do the surgical work. This appears impracticable for a number of reasons. First, sanatorium men are nearly all recruited from the ranks of physicians without surgical training and experience, which I believe are basic necessities in all good surgery. The man not trained in surgery may learn the technique of two or three special operations and become able to perform them with some degree of skill, but he will not do them as well as the trained surgeon who has concentrated upon this particular line of work. Every good thoracic surgeon that I know, with one or two exceptions, is a general surgeon and is still doing general surgery.

In the second place I know of no sanatorium in the country that offers enough surgical material to give one man the training and constant practice necessary to make him an able tuberculosis surgeon. When one man does all the surgery for a considerable number of sanatoriums and is in contact with a group of two or three thousand tuberculous patients, he is kept constantly busy, gains a wide experience and does good surgery. When he does the occasional operation that arises in a single small sanatorium, the contrary is apt to be true.

#### *How Surgery Can Be Made Available*

I believe that the solution lies in having a trained tuberculosis surgeon, not in every sanatorium in the country, but in every section of the country available to every group of sanatoriums. Two modes of procedure make this sectional distribution of surgeons practicable. One is for the sanatorium to send its patients to the surgeon to be operated upon at his own hospital as indications arise. The other is for the sanatorium to collect

on one or two days a group of patients to be operated upon and thus make it profitable for the surgeon to make the trip to the institution if it is a considerable distance away from him. I am trying to look at the matter from a practical point of view. The average tuberculous patient after he has been treated for months and has reached the stage where he requires surgical treatment, does not have a great deal of money left to spend on long trips to the surgeon, nor can he afford to pay the surgeon enough to make it profitable for him to travel a long distance to operate upon him. Therefore there should be a surgeon thoroughly capable of doing this work within a relatively short distance of every sanatorium, or the system of calling in a surgeon only when a group of patients have been collected should be used.

There are a number of clinics in the United States and Canada where good tuberculosis surgery is done and where training is available to those desiring to go into this line of work. It should be the aim of each sanatorium to find the thoracic surgeon most nearly within its reach and if there is none within a reasonable distance to induce some well trained general surgeon in its district to take up this specialized type of operating and make his skill accessible to its patients.

---

### The Value of Dramatizing the Daily Work of the Hospital

The special financial campaigns have drawn fresh attention to the problem of local publicity for the community hospitals, says the *News-Letter* of the Commonwealth Fund in speaking of the work of the community hospitals that have been sponsored by the fund.

It says: "In general the town dailies and weeklies circulating in the hospital districts have been friendly and cooperative, though not all the hospitals have learned how best to work with them.

"Perhaps the greatest deficiency in the educational work of the hospitals has been the failure of the superintendent in some instances to dramatize the daily service of the hospital in such a way as to catch the definite personal interest of board members. It is necessary to have the intelligent support of the board for the hospitals as a community institution and financial entity; this support might be materially strengthened if the bankers and merchants were directly exposed to the enthusiasm of the hospital personnel and got acquainted at first-hand with the fascinating procedures of the laboratory, the x-ray department and other working units behind the scenes."



# Hurd Hall at Johns Hopkins Honors First Superintendent

By WINFORD H. SMITH, M.D.

Director, Johns Hopkins Hospital, Baltimore

A MEMORIAL building has been erected at the Johns Hopkins Hospital, Baltimore, in memory of Dr. Henry M. Hurd, the first superintendent of the hospital. This building was made possible by the gift of the late George K. McGaw, a member of the board of trustees of the hospital and a warm, personal friend of Doctor Hurd. The hall, which has been in use about three months, will be formally dedicated in October.

Doctor Hurd was superintendent of the hospital for twenty-two years, from 1889 to 1911. As a teaching hospital, the Johns Hopkins Hospital in its early days occupied a unique position. Doctor

Hurd's interest in education, his sympathetic attitude toward development of the hospital as a teaching institution, his active interest in hospital publications, and in the development of the Johns Hopkins Medical Association, the Johns Hopkins Historical Club and the Laennec Society, marked an unusually progressive attitude on the part of the hospital administrator at that time. His influence among hospital administrators was great. It is particularly fitting that a memorial hall of this character should be erected in his honor because the hall will be used for those activities in which he was particularly interested during his life.



In this hall will be held the meetings of the various medical societies and other important gatherings in connection with the hospital and medical school. It will likewise be used daily for educational purposes in connection with the school of medicine and the school of nursing.

The building is a dignified and artistic structure. The interior is a combination of unpolished marble walls on the upper level and American walnut paneling on the lower level. The fixed seating capacity of the hall is about 250. There is, however, space which can accommodate 200 additional chairs. At the entrance to the hall is hung a large full length portrait of Doctor Hurd, done by Mr. Chase of New York, a distinguished American artist. On one side of the entrance to the hall is a large cloak room and on the other a lounge room. Patients may be brought into the hall through a passage-way underneath the terraces on either side.

The screen is a daylight picture screen, 8 by 10 feet, and the moving picture apparatus and projection machines are back of the screen instead of in front, as is the usual procedure. The blackboards are concealed in the projection in front of the curtain and are operated by electric push buttons. They can be brought up to any height desired. All windows can be automatically darkened by electrically operated curtains.

The hall's location is also particularly appropriate, occupying a position between the Osler Medical Clinic and the Halsted Surgical Clinic, which bear the names of two of the celebrated chiefs of departments with whom Doctor Hurd was associated in the early days of the hospital.

### How a Famous Mental Hospital Is Curing Paresis

Ninety per cent of the cases of paresis, an organic disease of the brain until recently held fatal, are being either arrested or cured at St. Elizabeth's Hospital, Washington, D. C., where the government treats nervous and mental diseases, according to an announcement by the Department of the Interior.

The achievement is the result of a new method of treatment which not only arrests or cures the disease, but has eliminated the early death of the sufferer heretofore resulting within five years after discharge.

This cure, strangely, is effected by the induction of another well known disease—malarial fever—which, however, is easily controlled, and can be terminated very promptly. It overwhelms the spirochaeta causing the paresis, and deci-

mates them. Inject malaria germs into a patient suffering from this type of insanity—general paresis—raise his temperature to 104 degrees for a number of successive periods, and the chances are good that the paresis will be overcome.

Dr. William A. White, superintendent of the hospital for twenty-eight years, recently made a report to Ray Lyman Wilbur, secretary of the interior, under whom the hospital is operated, in which he set out comparable results with two groups of paresis patients, one treated before the development of the malaria cure, and one afterward. He shows that of 214 consecutively admitted patients to the hospital suffering from paresis, who were treated by all the then known methods but without the malaria, 127, almost two-thirds, were dead within a year; at the end of three years but 26, one in 8 of the group, were alive, while at the end of five years but 5 of 214, one in 40, survived. There were no cures. After the new "cure" was introduced a group of 192 nonselected sufferers from the same disease were given the malaria cure, with the following remarkable results:

Only 18 cases, or less than 10 per cent, died within one year, while 174, all that survived the first year, are still alive five or more years after the treatment; 40 had been discharged from the hospital, and many others are at various stages of recovery or permanent improvement.

### Outwitting the Outwitters—An Almost Comic Opera

"It couldn't happen," some positive minded persons are apt to say. But it did.

And here's the story from the *Journal* of the Hospital Boards' Association of New Zealand to prove it.

"There was a touch of Gilbertian opera in the proceedings of the Westland County Council recently. Some time ago, the auditor-general took exception to the status of two members of the Westland Hospital Board who were representing the Westland County, and they resigned.

"The county council, after expressing appreciation of their past services, reappointed them. The auditor objected that these men could not be re-elected to the positions vacated, and they again resigned.

"The council accepted the resignation of one member and appointed the second member to fill his place, and then elected the other member to fill the first member's position, thereby overcoming the objection of the auditor-general."

# When Is the Charitable Hospital Liable and Why?

By W. F. SCHICK

Newark, N. J.

THE subjects of hospital liability and malpractice, and compensation rates applicable to charitable institutions should be given serious consideration by those hospitals that are supported by public funds.

Since the liability of pay hospitals is already definitely established, we shall concern ourselves only with the liability that may or may not be fastened on institutions of so-called eleemosynary organizations that are under the protection of the state law.

It is frequently maintained by the authorities of charity hospitals that their institutions as eleemosynary organizations are under the protection of the state law, that their endowments and contributions from private or government sources are adequately safeguarded and that, consequently, they have no need of hospital liability or malpractice protection.

Such a situation is similar to the case of the man who was jailed for some infraction of a town ordinance. He called his lawyer, giving him the facts. His lawyer was indignant. "Why, they can't put you in jail for that," he said. "Well, I'm in jail," the client replied.

With this in mind we might well seek a little light as to why charitable hospitals have been sued and judgments have been recovered and on what basis the decision of the courts was rendered.

## *A Significant Ruling*

The English courts in 1824 held that charitable institutions were not liable for the negligence of servants in the performance of a public duty with which they were entrusted by statute and that, therefore, there could be no recovery in suit. But (and after a lengthy discussion) these words are significant:

"It is enough that a charitable corporation, whatever may be the principle that controls its liability for corporate neglect in the performance of a corporate duty, is not liable, on grounds of public policy, for injuries caused by personal wrongful neglect in the performance of its duty by a servant whom it has selected with due care. But in such

case the servant is alone responsible for his own wrong."

In 1880, the question came up in Rhode Island in *Glavin vs. Hospital*, 12 R. I. 411. The plaintiff claimed damages on the ground of negligence of the corporation in the selection of an intern who was employed as a surgeon, and to whose surgical care the plaintiff was committed. The court held that the defendant was liable for its corporate negligence in the selection of its physicians.

## *Cases Involving Charitable Hospitals*

The plaintiff claimed damages on the ground of the negligence of the intern, while acting as a surgeon, in his careless and unskillful treatment of the plaintiff. The court held that the defendant was not liable on this ground, that the hospital does not undertake to treat the patient through the agency of the surgeon but only to procure his services, and that, therefore, the relation of master and servant does not exist. The hospital is only liable for a breach of its duty to use the proper care in the selection of the surgeon.

Damages were claimed on the ground that since the plaintiff was in a critical condition, it was the duty of the intern, under a hospital rule, to send immediately for an attending surgeon, and that it was the duty of the corporation, under a special provision of its charter, to put the rule in execution. The court held that, while the intern acts as surgeon, and, when so acting, he may not be the servant of the corporation, yet he also is appointed to perform other duties and that when he is acting in such a capacity the relation of master and servant exists; that the corporation undertakes in critical cases to send for one of its staff of surgeons. This duty is imposed upon it in pursuance of the special terms of its charter, and can only be performed by the corporation through an agent. The intern is its agent for that purpose, and his neglect is that of the corporation. For such neglect, the defendant, by reason of being a public charitable corporation, was exempt from all liability.

The court held that this broad claim was not



supported by any of the cases cited and that the theory of a public policy which forbids the use of corporate funds in any case to compensate for injuries inflicted is not sound. There is no such public policy, and the establishment of such a policy is a question for the legislature. The theory that the corporate funds are trust funds and that their use to pay a judgment would be a violation of trust, is unsound.

The court further held that the result of the English cases is: (a) Where there is a duty, there is a prima facie liability for neglect; and a corporation being created for certain purposes which cannot be executed without the use of care or skill, it becomes the duty of the corporation to exercise such care, and funds acquired for the purposes of its creation will be applied to satisfy a judgment for its default in this respect. (b) The corporate funds can be applied, notwithstanding the trusts for which they are held, because the liability is incurred in carrying out the trusts and is incident to them. These rules for corporations for public purposes apply equally to corporations like the Rhode Island hospital.

In the case of *Hearns vs. Waterbury Hospital* (1895), the courts decided as follows: The patient claimed unskillful and negligent treatment of a fractured knee. The decision said, "A hospital which is a charitable corporation is not liable for injuries to a patient due to negligent treatment by the physicians and nurses employed by it, where it has exercised due care in their selection."

So we have the liability clearly established in these cases. Also we have the fact established in cases when a charitable hospital is not liable but when nothing is really settled until suit is brought on the point of selection on which it is tried and until the jury and courts decide in favor of the hospital.

#### *An Opening Wedge to Recovery*

In the case of *Taylor vs. Flower Deaconess Home and Hospital*, 135 N. E. 287 (Ohio), a patient sued for recovery of damages resulting from personal injuries received by him while he was a patient in the hospital in Toledo. The plaintiff predicted his right of recovery on the negligence of the hospital in its failure to use ordinary care in the selection of and retention in its employ of a certain assistant student, who is alleged to have administered an injection of scalding hot water immediately following an operation for appendicitis. The court decided that the hospital was liable and used the following language:

"Where a public charitable hospital has failed to exercise due and reasonable care in the selection of physicians, nurses or attendants, and injury results

from the incompetence or negligence of such persons, the hospital is liable."

It can be readily appreciated that under these decisions the actions were not brought because of the actual malpractice of the servants, but because they would not have occurred had due care been exercised in the selection of that service. This seems to be the only opening wedge to a recovery that can be used.

#### *Providing Beforehand for Emergencies*

Many cases may be cited to substantiate liability on the part of these eleemosynary institutions, and as a rule when due care has been exercised they have been held not liable. One recent case, however, would seem to remove all barriers for suits. This was a recent decision in New Jersey by which a judgment of \$7,500 was returned against a hospital, based on injuries suffered by the patient in a fall down stairs in the hospital. The judge in this case refused to grant a motion by defense counsel for a nonsuit on the ground that the hospital being a charitable institution cannot be held in damages for injuries suffered as a result of negligence on the part of the employees or agents. This decision went even further than the foregoing cases in which recovery could only be had when due care was made in the selection of such employees or agents. This decision seems certainly to differ from the rulings that have, as a rule, been made heretofore.

#### *Two Types of Policy Are Needed*

It should be noted that in the case of a hospital, two vital forms of liability are always of importance: Where any of the public or patients are injured in, around or about the premises, a general public liability policy should be carried. Where any of the patients are injured as a result of medical or surgical treatment then a hospital liability (malpractice) policy should be carried.

The time for filing suits is two years. Liability, however, may remain dormant for years as this limitation does not hold against a minor until he is of age. Recently, we received notice of a claim in which the injury was supposed to have occurred nineteen years ago.

Suits have been filed in amounts from small sums to more than \$100,000, and in some actions claims have been filed against both the hospital and the person causing the injury. It seems wise and expedient, therefore, to provide for these emergencies beforehand.

Recently a hospital in California was sold under the hammer to satisfy a judgment of \$8,500. Cases like this should convince us that the matter of protection should receive our earnest, serious attention.

# Enhancing the Hospital's Service by a Photographic Unit

By R. C. BUEKKE

Superintendent, State of Wisconsin General Hospital, Madison

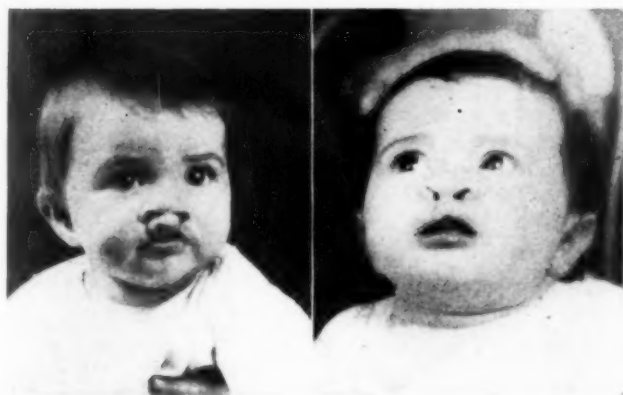
IN EVERY hospital of two hundred beds or more, money spent to install a photographic department will be well invested. It will not only be a protection in possible suits for malpractice, in which both the physician and the hospital may be involved, but it will produce, in addition, revenue practically sufficient to pay for its own maintenance. When a photographic department is once established and made available to physicians of the hospital, its many and varied uses will rapidly become apparent.

Every hospital patient who has any condition which may be photographed should have a picture taken both before and after treatment. This adds to the completeness of the record and will frequently be of great satisfaction to the patient, who in this way can follow his own case intelligently. Pictures should be taken of all accident cases

son, has in its photographic department, two workers who devote their entire time to photography. The department is equipped with one 8 by 10 camera, one 5 by 7 camera, one 5 by 7 camera of a special type, one 16 m/m moving picture camera and one 32 m/m professional moving picture ma-



Another double cleft palate and harelip before operation and one year later.



Case record photographs of double cleft palate and harelip before operation and one month later.

brought to the hospital as emergencies, the vast majority of which eventually appear in court.

The American College of Surgeons has stressed the necessity of instructive staff conferences for so many years that today every staff member wishes to demonstrate, as graphically as possible, methods of procedure and the results obtained. Photographs and lantern slides, as well as x-ray films, tend to simplify and dramatize the presentation of an unusual case or series of cases.

The State of Wisconsin General Hospital, Madi-

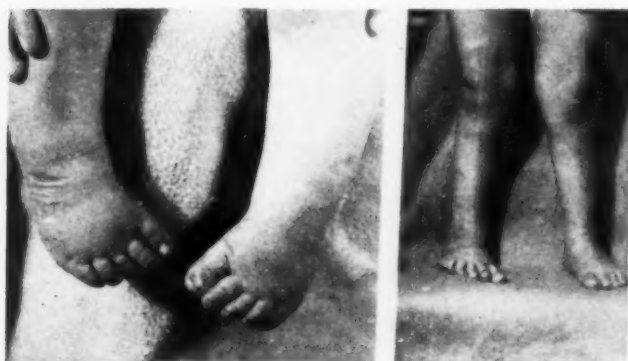
chine. All of the cameras are equipped with the special lenses necessary for adequate photography. During one month this year, the photographers took 362 photographs, made 905 prints, 6 color plates, 108 lantern slides and also took 600 feet, 16 m/m film and 200 feet of 32 m/m film at a cost of less than \$350. This cost included salaries, all supplies and depreciation. Paid for at commercial prices, the cost would have been very much greater.

A detailed discussion of the many and varied uses of photography in the different departments may be of interest to any institution contemplating the installation of a photographic department.

Each patient admitted to the orthopedic, dermatologic, ophthalmologic, otolaryngologic and neuropsychiatric services, whose condition can possibly be reproduced in a photograph, has pictures taken from as many angles as are necessary to demonstrate the condition fully. Then, following each major procedure during the patient's stay in the hospital, check-up photographs are taken. When

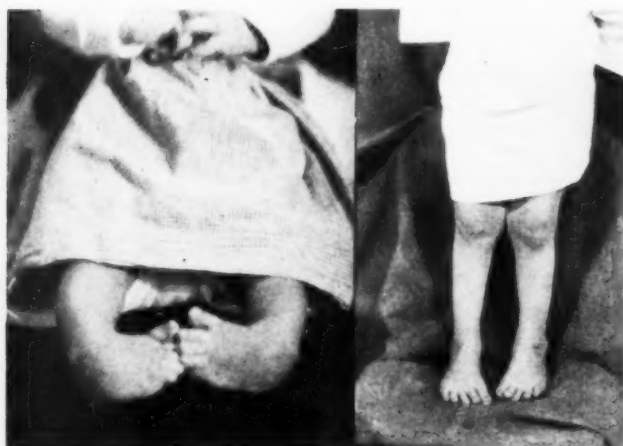
he is discharged a final photograph closes the case. The oral plastic service photographs every case, regardless of its severity, and follows these cases throughout with photography.

The major departments in medicine and surgery, while they do not use the photographic laboratory



for routine cases, find many patients who need photography, not only as a protection to the hospital and to the physician, but as material for staff demonstrations and for teaching. By mounting a moving picture camera on the operating room lights, we have been able to take moving pictures of interesting operative procedures with a minimum of inconvenience to the surgeon. These pictures are later used in lectures and demonstrations before medical students, student nurses and staff conferences of this and other hospitals.

One member of the department of pediatrics, who has been interested in amateur photography, has developed an excellent series of films in the



*This and the upper picture are case record photographs of clubfeet before and after operation.*

routine care and examination of the infant. He has found that all too frequently, although we have a large pediatric service, he is unable to find the type of case he wishes to demonstrate. He has therefore resorted to pictures.

When the hospital is run in connection with a

medical school, the value of photographic work in preclinical sciences has been repeatedly demonstrated.

One of our scientists, Dr. Walter Meek, recently said: "Photographic recording methods are now a part of every laboratory. The invention of fast bromide papers and long roll films has made many types of recording instruments available both to the physiologist and the clinician. Almost all we know about muscle, nerve and the action currents of the heart depend on such devices.

"The moving picture machine has been appropriated both for teaching and research. The energy expended in any type of work or locomotion may now be computed from fast films slowed down



*A picture of a sarcoma of the femur was used as medical legal evidence.*

when projected so that the movements may be analyzed. Development in the use of human muscles may in this way be studied for the first time accurately. Many lessons will be learned from these studies that are applicable to the problems of retraining crippled children.

"In teaching, the movie has for some time frequently supplemented the lecture. Experiments which are duplicated only with difficulty and needless expense may be photographed. Their presentation stimulates interest and the psychologic effect is, therefore, good. Even the Mickey Mouse type of movie cartoon has proved useful in presenting physiological processes. An interesting and valuable film has been devised along these lines to show the passage of the impulse over the mammalian heart. By taking a long series of pictures of tissue cultures the slow development of cancer cells may be hurried into a rapidly moving story.

"With the new sound attachment even the lecturer may find himself almost a movie operator."



# The Hospital Holds a "Clinic" Over the Incoming Patient

By E. L. PLACE

Business Manager, New England Sanitarium and Hospital, Stoneham, Mass.

WE HAVE been giving considerable study and thought to the matter of perfecting the service of the New England Sanitarium and Hospital, Stoneham, Mass. We have endeavored to run down every complaint, ascertain the cause and apply the remedy. To do this more effectively we called together a group of our department heads and others who have a direct contact with the patients or who have a definite part in supervising service—thirty in all. We called this meeting "a 'clinic' over the incoming patient."

We pictured the patient arriving at the front entrance of our hospital, and from that point we followed him through the various services of the institution so that we might check the efficiency of those services to the minutest detail.

As the "clinic" progressed many irregularities were brought to light. The following are a few of the points of service considered:

1. The courteous and friendly reception of the incoming patient by call boys, the desk clerk and the admitting department.
2. Patient shown to his room quickly, thus avoiding long delays following his arrival.
3. Room previously inspected to make sure that everything is in readiness.
4. Quietness—quietness—quietness.
5. Supervisor, physician and matron to see this patient soon after his arrival, thus getting him off to an early start in his health program.
6. Adequate general nursing help to answer bells promptly.
7. A sufficient number of call boys.
8. All apparatus in the treatment rooms in perfect working condition.
9. Plenty of heat from noiseless radiators and pipes.
10. All rattles, squeaks and creaks in the floors, the doors and the equipment eliminated.
11. Food served well cooked and appetizing.
12. Hot foods hot; cold foods cold; dishes hot; trays hot.
13. A sufficient number of waitresses in the dining room.

14. All call bells in order; those out of order should be fixed promptly.

15. Everybody talking in an undertone night and day.

16. The patient started on his treatment and examined soon after his admission.

17. Prompt and courteous answers over the telephone.

18. Trays delivered promptly.

19. The best quality of foods.

20. Comfortable beds, made so with best mattresses and springs obtainable.

21. Patient's complaints reported promptly.

22. Visits to other hospitals and hotels made by department heads to obtain new ideas on service.

23. Comfortable chairs in all the rooms.

24. All menus checked by a physician or a dietitian.

25. Prompt report of the patient's condition to responsible friends and relatives.

26. No errors in the bills.

These are only a few of the matters that have been considered. We are holding these "clinics" periodically for the purpose of keeping our service at the highest level possible. Criticism is indulged in freely even when it hurts, and we have concluded that from the leaders straight down through our working force of 180 we must make everything secondary to the interests of the "most important person in the hospital—the patient."

## More Clinic Cases at Grant Hospital, Chicago

During 1931, 10,052 patients were seen in the out-patient department and clinics of Grant Hospital, Chicago. Of these 6,836 were charity cases; 340 patients were admitted to the hospital from the clinics; 16,347 free days of hospital care were given the charity cases; 1,585 were given to part-pay patients.

There has been an increased attendance in all clinics during the last few months. The heart clinic is especially overcrowded.

## Practical Administrative Problems:

# Sane Methods of Credits and Collections

**D**URING the past score of months, a somewhat altered trend in the financial activities of hospital managers has become apparent. Strenuous efforts have been and are still being exerted to increase the income of the hospital in order to meet the ever harassing deficit. In many instances, however, it appears that the superintendent, having convinced himself that his hospital's patients are unable to pay higher fees, is now centering his efforts on avoiding spending a single dollar more than is necessary.

### *A By-Product of the Depression*

It must not be hastily conceded, however, that those who patronize the hospital are always willing to meet their expenditures promptly, even though they may be able to do so. A by-product of the financial panic that has seized the country as a whole is the attempt to avoid the expenditure of money for any purpose because of a fear of being unable to subsist until the emergency ends. Persons who have hitherto shown no tendency to evasiveness seem now to be consciously or unconsciously guilty of acts that smack strongly of insincerity if not of dishonesty.

None senses this psychologic trend more intensely or more understandingly than does the institutional credit worker. Reasons purporting to explain why private room and ward rates cannot be met seem, more easily than ever, to spring to the lips of the person being interviewed. In some instances it is suspected that the existence of present, or the fear of future, financial reverses is put forward as a sort of smoke screen to confound this worker. The directors of hospitals, therefore, should not cease in their efforts to require the payment of honest debts. While hospital fees cannot of course at this time be raised it is probable that in most instances they have reached their lowest reasonable ebb. To permit the rendition of service without requiring an honest effort on the part of the recipient to meet the expense is fair neither to the hospital nor to the persons involved.

It is the purpose of this article to direct attention to methods by which financial leaks occur and in so doing to refer briefly to certain plans by which incomes may be increased. The time old

adage that warns against "saving at the spigot and wasting at the bung hole" is applicable to many activities in life. It is necessary, of course, for the hospital executive to be certain that no major leaks have crept into the administration of his institution. On the other hand, long continued minor wastes can produce in the end the same state of financial exhaustion that is seen when funds are squandered lavishly over a short period. The administrator must therefore not only employ a low power lens that permits him to inspect the details of his whole financial program, but also he must scrutinize more intensively certain of the relatively unimportant financial transactions in his search for preventable waste. Financial leaks may be large and still remain unobserved. Minor waste is perhaps more elusive yet equally devastating in its effect.

Resorting to a medical simile to emphasize this point, I would say that as the physician frequently observes the existence of a severe anemia threatening even to life, which has resulted from a slight hourly trickle of blood, so hospitals in the same manner may be bled white from a financial standpoint, when similar small economic leaks exist. It should not be necessary, however, to state early in an article of this sort that it would be the greatest lack of wisdom to assume a miserly attitude in conducting an institution. While no minimum daily rate consonant with good hospital service can be set, it may be said with certainty that when the amount of money spent per day in the treatment of a patient reaches an unreasonably low figure, poor service is almost certainly being rendered.

### *The Decrease in Private Room Occupancy*

It has been noted in all hospitals, during the past twelve months particularly, that a downward movement has taken place in the economic status of hospital patients. The de luxe suite is prone to stand empty, the middle grade accommodations to be more frequently engaged, and the less expensive private rooms and semiprivate beds to present a higher percentage of occupancy. Waiting lists for ward beds have gradually lengthened, and the free ward percentage of occupancy has appreciably mounted.

As has been intimated there is but little question that in many instances the patient has obtained free treatment at the hospital by pleading the disastrous effects of the present economic disturbance. The business, therefore, of giving hospital credits has become increasingly more difficult from the standpoint of protecting the interests of both the patient and the hospital.

#### *When Patients Don't Pay*

In a certain New England hospital of 115 beds, it was noted at the conclusion of the year's business for 1931 that approximately \$1,000 a week had remained uncollected, for service for which patients had promised payment. In analyzing this annual loss of \$52,000 it was found that many of the patients who left the institution without settling their accounts had occupied private and semi-private beds. A great many others had been treated in the wards, had agreed to pay at a fixed rate, but through some subterfuge or on the basis of some frail or false excuse had been allowed to go home without having met their obligations.

Moreover, in this particular institution, it was discovered that not only was a careless credit system in effect but also that it was impossible to learn accurately how much money had been lost through the failure of patients to meet their bills because there was no check between the daily or monthly receipts and the bank balance at the conclusion of either of these periods. In other words, the monthly bank balance did not equal, as it should, the difference between the total receipts for the month and the disbursements for this time.

Surprising as it may seem, there are many hospitals in which the same condition is to be found in a more or less aggravated form. To be sure, there are certain instances in which for justifiable reasons the patient may be placed in what should be an income producing bed for which service no charge is made. On the other hand, no such condition should exist as depicted by the following statistics. In the institution to which reference has just been made 22 per cent of the pay cases were medical; 32 per cent surgical; 2 per cent pediatric; 17 per cent obstetric; 21 per cent nose and throat, and 5 per cent orthopedic.

Of this group, 27 per cent of the patients were treated in private rooms, 28 per cent in semiprivate accommodations, 31 per cent in general wards and 13 per cent in the pediatric department. Of the accounts remaining unsettled at the conclusion of the year's work, it was found that 22 per cent of the total number of free patients were treated in private and semiprivate rooms.

This situation is of course difficult to understand. There may exist some local and easily understand-

able reasons which when revealed would amply explain such a condition. On the other hand, here is evidence of a dangerous leak which, when brought to the attention of the governing body, should be immediately remedied. Perhaps in the institution referred to the fact that physicians are permitted to charge ward patients for services rendered might tend to produce a condition whereby difficulty in securing the full payment of the hospital bill would be likely to arise, because the greater portion of the patient's resources was required to meet the fee of the physician.

If such a situation exists in any hospital let the administrator convince himself that a ward bed which at the best is rarely self-supporting, is not being rendered less so because of the fact that the surgeon or internist is permitted to charge for the service he renders its occupant. This is a pernicious practice, and if hospital executives who possess as they should sufficient moral stamina to reveal its dangerous possibilities to the institution would take a decided stand in the matter, the hospital would certainly be benefited financially.

A new standard is being developed that expresses the obligation of the hospital to its community. No institution worthy of the name will permit itself to be continually embarrassed by persons who demand the best of service and are unwilling yet able to pay for it. No hospital is expected to provide, without limit, good service at no expense to those receiving it. Good service at a minimum rate does not smack of a lack of humanitarianism but indicates a business acumen on the part of the hospital. This refers to private institutions, and not to federal, state, county or municipal hospitals supported from tax funds.

#### *Future Policies for Indigent Care*

In laying down this dictum, which is in no way applicable in all instances, I am fully cognizant of the fact that in many localities tax collecting agencies have appreciated and voted adequately and honestly to meet to the fullest extent their responsibilities. The private hospital of the future will provide efficient hospital service at a varying cost to the patient, but will expect and demand that county, municipal or state funds be forthcoming to meet the expenditures necessary for the care of the bulk of the indigent patient load. If one lesson has been learned from the present financial condition it is that the private hospital cannot expect public or private donations to continue indefinitely to provide a means for meeting mounting hospital deficits. The time is not far distant, it is felt, when this type of hospital will be forced to refer to institutions maintained by tax collecting bodies all indigent patients seeking aid, except



those for whom some emergency exists. When such institutions are not available then a demand must be made that some just financial agreement be decided upon between the hospital and the custodian of tax funds.

#### *Demanding Justice From Public Officials*

It is readily conceded that such a doctrine will be considered heresy in some circles. Nothing, however, has been or will be said with the intention of detracting from the splendid traditions of service upon which the hospital is built. To demand from lethargic or cowardly public officials, however, the practical recognition of their obligations is but an act of good business on the part of the hospital. Financial dealings with city or county authorities will never be devoid of difficulties.

In a large Eastern city there still exists a number of independent poor districts which continue to collect their own poor tax. The regularly organized municipal institution for the care of the sick demands and receives from these districts the payment of \$3 a day for each indigent patient accepted. Private hospitals accept such patients with no expectation of being paid for the expense they incur. In another Eastern city, a general hospital of approximately one hundred and twenty-five beds, provided during a certain period 27,000 days of service to indigent patients, for which it received \$44,000 from the county treasury. This payment, which averaged \$1.70 a day per patient, in no way reimbursed this hospital for its service.

Such unfairness to the hospital and to its contributing public will continue as long as spines are weak and politics are permitted to prevent the exercise of sound business sense. If in localities where there are several hospitals affected by this situation, a concerted effort could be made by all to bring about a satisfactory recognition of the justice of their claim, some hope may exist for the remedying of this difficult situation. Until then, however, these institutions will continue to receive indigent, ailing patients from the county jail, the local almshouse and the cheap lodging house, and with little protest will go on rendering them adequate and humane treatment, with the inevitable loss of money. If any hospital, therefore, has been without protest gradually accumulating a deficit it can hardly hope to meet, the attention of its board should be directed to the possibilities of adopting this avenue of escape.

In some institutions, it is the custom to permit the placement of private nurses for service to ward patients, even though the hospital bill for board, service and medicines is not being met. In one institution, a child suffering with meningitis

received during a period of eight weeks, serum costing \$120 and board and maintenance amounting to twice this amount, without the hospital being reimbursed. When this patient was very ill, however, night and day special nursing was provided by the family at the customary cost. This circumstance is repeated in some degree many times during the year in many hospitals. It does not seem reasonable, except in unusual instances, to permit the placement of private duty nurses for ward patients until the hospital's bill has been met.

There is a type of ward physician who may be classed as the "tomorrow-will-do" variety. It matters little to him that for each day's stay of the patient in the ward, the hospital is required to spend from three to four dollars. He is tardy in beginning a study of the case. He does not arrange to arrive promptly at a diagnosis and to institute treatment. The matter of the expenditure in time of a few days or a week is apparently of little moment. This type of physician is surely responsible for the needless expenditure of hundreds of thousands of dollars annually throughout the hospital field. A closer supervision is the only answer to this difficulty. It is not uncommon for a patient in the hospital for medical study to occupy a ward bed for several days before any well conceived plan of action has been decided upon or treatment ordered. When the laryngologist operates only twice a week, a tonsillectomy must be delayed for several days until this operating day arrives, a needless expenditure of more money.

In some hospitals, a persistent failure to interview patients' relatives on visiting days is brought about by the lack of a system whereby the credit officer learns of the presence of such persons within the institution. A card proceeding from the credit officer to the head nurse on the ward, notifying her of the presence in the hospital of persons desired for an interview and returned at the end of the visiting hour notifying the credit officer as to the absence or presence of such persons, has proved effective in some institutions.

#### *Economies That Can Be Effected*

The hospital that is unable to take advantage of cash discounts is losing from 0.5 to 1 per cent of its total expenditures excluding those for salaries. An institution in which young physicians in the community are permitted to serve as anesthetists, charging from ten to twenty-five dollars for each anesthesia, is losing a considerable sum of money for which there is little excuse. In one hospital of approximately one hundred beds, many of which were for the care of surgical patients, \$7,195 was collected in one year for anesthesia fees. This institution could well afford to pay a highly skilled

anesthetist \$1,800 a year and still realize a splendid sum on this activity. Moreover, the system that permits the operator to bring in his own anesthetist has its dangers, and it is a matter of serious question whether such anesthetics are as well or as safely administered as would be the case were a skilled graduate nurse anesthetist always on hand to assist the surgeon.

#### *Controlling Ward Medication*

Many efforts have been made to control the amount and type of medication ordered, particularly for ward patients. As yet, however, no scheme has been devised that will wholly counteract the pressure brought to bear on the physician by biologic and other houses. His office is daily flooded with literature describing in the most lurid terms the advantages of new drugs. These preparations soon find their way into his system of prescribing for hospital ward patients.

As has been indicated frequently in this department, it is impossible to avoid expenditures for certain specific drugs, of which liver extract is a good example. The hospital should not endeavor to evade the purchase of such drugs and thus deprive its patients of life-saving remedies. On the other hand, there are a large number of costly preparations which are persistently employed, particularly by the internist. The hospital is justified in demanding that this practice cease, and in purging its drug shelves of any preparation not recognized by the Council on Pharmacy of the American Medical Association or by the United States Pharmacopeia. One institution of less than one hundred beds collected in one year \$4,398 for drugs prescribed by physicians. In some hospitals a blanket charge is made covering all drugs used. In others, the ward patient is never charged for drugs of any kind. Some system consonant with local conditions should be worked out to avoid this unnecessary leak.

#### *A Dispensary Economy*

Does the hospital's obligation extend to the point of providing medication without stint to dispensary patients? A case of pernicious anemia, in which the patient was treated at a medical dispensary, has been known to cost the dispensary at least \$150 a year for liver extract. It does not appear to be always the obligation of the hospital to provide such drugs without cost. Some community charitable agency should be required to meet a part or all of this expense. Particularly is this true when one remembers that the hospital is not expected to provide the patient with funds with which to procure food and lodging and following this matter to its logical conclusion, it is perhaps within the

bounds of common sense to suppose that the same agency that provided these commodities, should also endeavor to supply medicines.

This whole problem, hospital and community responsibilities, is so complicated that perhaps it will never be placed on a standardized basis. I have discussed some of the major and minor leaks that have been known to creep into the hospital financial system. The most important subject facing hospital administrators today is that which concerns itself with a differentiation between the obligations of private charity and of the institutions and agencies supported by public funds. To demand payment for hospital service is not inhuman. To refuse a necessary hospital service because no money is available and no other facilities are at hand represents a forgetfulness of the purpose of the hospital, and is inexcusable. A confusion of these truths has perhaps led to the present unbusinesslike situation in the hospital field. It must be clearly understood that there has been no intention of urging in any of the foregoing statements that the fine record of service to the public, of which the hospital proudly boasts, should be marred by the adoption of any mercenary policy. On the other hand, the private hospital is fighting now for its very existence. The public institution will not fail financially unless government itself dissolves. Fair play for the privately endowed hospital at the hands of governmental agencies should be demanded.

---

### Increased Service at Reduced Cost for These Young Patients

How the work of the Children's Hospital, Columbus, Ohio, during 1931 increased over that done in 1930 is shown in a comparative statement of the amount of service given during the two years and presented by the superintendent, Eva Ellen Janson, in the annual report.

Visits to the out-patient department numbered 27,974 in 1931, an increase of 14,660 over 1930. Patient days numbered 25,317, an increase of 1,812 over the preceding year. Admissions totaled 2,313, an increase of 475. The average stay in the hospital was 10.9 days, a decrease of 1.1 days over 1930. The number of x-ray examinations given was 1,311, an increase of 693 over the preceding year. Laboratory tests, which numbered 18,784, showed an increase of 4,972. The cost per patient was \$3.70 a day, a decrease of twenty cents. The total cost of running the hospital was \$93,767, which represented an increase of only \$1,577 over that of the preceding year.



# Editorials



## A Word of Cheer for Lugubrious Administrators

THE worries of many hospital administrators have kept pace with the depression. Faces are longer than usual, brows more elaborately knit. Uncertainty glooms their future and optimism is at a premium.

Serious minds today want more than platitudes about silver linings, sunshine after the rain and all such. Slogans by the Pollyannas about smile and the world smiles with you, have been consigned to the wastebasket. The administrator does not want to be reminded of his present mental pathology.

But all hospital workers will find infinite consolation if they will but take inventory of their "trade." Hospitalization is an activity than can never seriously be jeopardized by adverse economic situations. It has to survive. A man with little funds can minimize his patronage of landlords and publicans and greengrocers. But he can not forego his doctors and his hospitals. When he is sick he needs care. And, poor or rich, he has to get it.

Hospital administrators should realize that theirs is an essential profession. The institutions committed to their care are not going to be closed the moment a bit of red ink shows up on the ledger. Certainly the public—regardless of whatever else it *can* do without—can *not* do without hospitals. Your profession, your staff and your workers are performing an indispensable service that has existed since the beginning of civilization.

If optimism is needed in the hospital field today in more individual cases, it is this sensible kind—not the chin-up, chest-out sort, but a rational and intelligent encounter with facts. The administrator will have to see with a deep, penetrating vision and not get all worked up over the trivialities that have accumulated on his glasses or on the end of his nose.

He will have to pride himself on the fact that his is a business that has higher motives and justifications than profit. Then he will be able to realize that hospitals are not going to be consigned to oblivion if the world at large (in a commercial sense) fails to find an up-grade around the next corner.

As in other years, ten million people will again need hospital service. Fewer of them than in the past will have much capital. If their lack of funds is going to distress the owners of movie palaces and summer resorts, it is not going to shut the doors of hospitals. Occupancy of hospital beds has secondary relationship to funds or lack of them on the part of the individual. Adequate care of the sick is a public responsibility that must be accepted, good times or bad.

The responsibility will be met and the lugubrious administrator will snap out of his dejection when the broad aspect of hospitalization inspires him with the truth that his is an eternal occupation, traditionally and morally tied to uninterrupted progress and not at all in the habit of collapsing every now and then.

## Honesty Versus Politics

AT THE Detroit meeting of the American Hospital Association in September, a new and important section of hospital administrators will meet to discuss mutual problems. It will be composed of the superintendents of municipal and county tax supported hospitals, and all indications point to a most interesting session conducted for the benefit of the largest bed capacity institutions in the United States and Canada.

Among the tax supported group are such excellent hospitals as the Cincinnati General Hospital, Cincinnati, Grasslands Hospital, Valhalla, N. Y., Fairmont Hospital, San Leandro, Calif., formerly the Alameda County Hospital, Ancker Hospital, St. Paul, Minn., and many others of equal standing.

Unfortunately, also in this group are many politically controlled and hopelessly corrupt institutions that have brought shame and disgrace upon all of the hospitals of the country. In one hospital two patients are allowed to occupy the same bed; in another the death rate is abnormally high and the insanitary conditions would have brought indignant protest from the people of the sixteenth century; a third openly deals in petty graft, and in another it is said that internships and residences are actually sold to the highest bidders.

The time has come when all tax supported hospitals must bring their standards up to those of Cincinnati, Grasslands, Alameda and Ancker, and from whose doors cheap and disgusting politicians must be driven now, once and for all.

Politicians have organized orderlies and domestic help into unions for the support of their particular political parties and, through the politically controlled administrator, have dictated who shall and who shall not be hired, irrespective of ability.



Recently in a political upset in one of our larger cities, the administrator was threatened with the loss of his job because he voted the Republican ticket. There has been no question raised as to his ability, his services to the city's poor over a number of years, or as to what may result from a change in the superintendency—his position evidently depends solely upon how he votes.

These cesspools of corruption will continue defiantly until action is taken by responsible rating bodies, and it is squarely up to the American Hospital Association to protect its honest members by condemning and repudiating any hospital in which there is even a suspicion of graft or political influence. It is squarely up to the American College of Surgeons to take from its list of approved hospitals those that are known to be politically controlled, and it is squarely up to the American Medical Association to remove from its list of ethical hospitals those tax supported institutions that have been made political footballs and in which interns are taught to lie, cheat, steal and be discourteous. To countenance further these affronts to decency or to believe any longer the promises of reform is to insult every ethical hospital in the country. There is little point in establishing minimum standards when corrupt hospitals can get away with subminimum standards year after year.

Politics and hospitals must be absolutely divorced. The evidence is clear, and the rating organizations must admit equal corruption or demand that crooked politicians turn back the tax supported hospitals to the citizens and that they be so conducted as to be an asset and a benefit to all.

## The Graduate Nurse Needs Our Help

ON PAGE 108 of this issue appears a news story giving the essence of a letter that has been sent out by the national nursing organizations—the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing. Every hospital administrator in the country should give it earnest and thoughtful attention. Unless we are willing to face a complete demoralization of our profession we must be ready to protect our own. The nurse and her future are our responsibility, and we must help as we can when help is needed.

The best interests of every hospital on this continent would be served the better were it possible for all of their nurse graduates to be happily and profitably employed. Like the rest of us—even perhaps to a greater degree—the nurse has suffered at the hands of economic conditions, but true

to the fine traditions of this profession she has suffered for the most part in silence and has accepted the "reduced rations" in the noble spirit of sacrifice.

Now her national associations are proposing that some of her woes can be alleviated if the hospitals will help, and we strongly endorse this movement, for while the hospitals are looking for some relief themselves they should also be willing to offer relief to nurses whenever it is possible.

## Mental Patients and Mental Attitudes

THE public hospital, supported by the taxpayer, and the voluntary hospital, supported by voluntary contributions, have identified themselves in this country with certain types of patients for whom they assume partial or complete responsibility. Perhaps it would be more correct to say that the voluntary hospital has so identified itself, in its willingness to finance the care of certain highly desirable types of patients, leaving those whom it considers otherwise or for whom there is no more room in its wards to be cared for by the public hospital. The voluntary hospital exists as a free offering of the contributing public to the community. The taxpayer, through his political representatives, not having fully learnt to apply the lessons taught by the voluntary hospital, has come to know the danger of looking a gift horse in the mouth. The public hospital thus provides for the leavings and for undesirables who arrive by transfer, in addition to those who seek its services in emergencies or in the belief that the public hospital is or should be as good in quality as the voluntary hospital (as many of them are).

But workers in the hospital field may at least express some doubt as to the wisdom and justice of the distribution of clinical material on any other than scientific and humanitarian grounds. The sick man who has all the luck is in the acute short term classification—not too acute, because then he has no choice—has an interesting and tangible condition and meets the requirements of the voluntary hospital on social, economic and clinical grounds. Patients in all other classifications must take their chances with the facilities of any kind of hospital that may be at hand and is willing to accept them, and must submit to the consequences.

Contagious diseases, chronic diseases and mental diseases are time-honored charges on the taxpayer and there are few voluntary institutions that will admit patients in these classifications. Yet they

possess communal values that are almost incalculable, in spite of the clinical position that tradition has assigned to them. Ever since Pinel struck the chains from the insane at *La Salpêtrière* in Paris, humanity has been priding itself on the treatment it gives (or no longer gives) to the alienated sick. The fact is, however, that institutional progress in this direction has been slow and narrowly limited. The stigma of mental disease still brings misfortune to the family as well as to the patient.

Hospitals for the mentally ill, mostly public and mostly perfunctory in their conception and in their maintenance, exist independently of hospitals, while the humane and scientific touch of the voluntary hospital, which has been so successful with its selected clientele, is noticeably absent. For those ambulatory cases in between, who are not exactly alienated, but whose psyche has undergone trauma, as the expression goes nowadays, plenty of effort has been expended. Schools of psychotherapy have indeed come into being and flourish, with the object of bringing these patients back to normal.

What reason, if any, is left in this day and age for refusing the mental hygiene institute and the psychiatrist their proper place alongside the voluntary acute general hospital where patients diseased in mind, as others are diseased in body, may enjoy all the blessings that the hospital staff, hospital facilities and hospital equipment alone can give? When will the barrier that separates these two great classifications of disease be removed, and when will the mental patient be accorded the same considerate treatment that we give to the one who is also afflicted, through no fault of his own with, let us say, acute appendicitis or acute lobar pneumonia?

Not until that day of balanced mental attitudes toward mental patients will scientific and humanitarian treatment be accorded them, and then alone will they and their families be relieved from the stigma that exists only because an unkind community makes it so by its inconsiderate isolation and segregation of the facilities for their treatment.

### July Days in the Hospital

THE arrival of the disturbing necessity to take steps for fly prevention; the need for greater care in food refrigeration; the deadly effect of heat on the postoperative patient; the demoralizing result of the absence of many vacationing nurses and staff physicians; falling private room occupancies; fatigued executives—these are some of the accompaniments of midsummer in the hospital.

Yet, in times of low census, it is wise to prepare for busier days by refreshing paint and hangings. A long delayed physical improvement to the dispensary or operating suite, a painting of outside walls or a repairing of roofs may now be safely initiated without seriously disturbing the hospital routine. Long before this the thoughtful forehanded executive will have caused fly screens to be placed and ward fans to be repaired and distributed. To engage graduates to prevent understaffing in the nursing department during vacation may be an act of wisdom, and a vacation substitute schedule for the professional staff is always necessary.

Despite the disturbing difficulties of a torrid July, however, the superintendent needs recreation and rest to prepare him to perform his work well during the coming season. To go is often expensive, but to stay is frequently extravagant in its tax on health and strength. A board of trustees that does not recognize this fact is lacking in vision. Prepare now for what will surely be a busy institutional season ahead.

### Staff Membership in Local Medical Organizations

MUCH has been said and written by lay persons who have seen fit to criticize the medical profession relative to the trends and motives of so-called organized medicine.

It has been claimed by the physician's critics that the medical profession through its various county, state and national societies has endeavored to stifle free thought and to force upon an unwilling public such preventive measures as vaccination against typhoid and smallpox and the treatment of diphtheria and tetanus with serums. Medical organizations are the subject of censure from what appear to be ill-informed groups because they insist upon proper training and experience for all those who are permitted to practice the healing art. It is stated by others that the reputed altruistic traits that are ascribed to the physician are essentially self-seeking in nature although they are masked as beneficent acts.

The county medical society, made up as it is largely of general practitioners, is capable of rendering a great service to any community. The hospital should require that members of its staff identify themselves with the local medical society. In this way, it will be encouraging the practice of medicine on a high level and will be recognizing the fact that the best and safest physicians in the locality are usually to be found among those who actively support such an organization.

# Is Your Problem Answered Here?

## HOW CAN REVERBERATING WALLS BE TREATED?

Recently in a new hospital in the East the noise of footsteps and even of ordinary conversation became so multiplied by reverberation from smooth plastered walls that patients repeatedly complained. The hospital was constructed in the best and most modern manner. Precautions against noise, however, had not entered into the planning of the architect, and private room corridors became veritable sounding boards for slamming doors, the talking of patients and their relatives and the many other heterogeneous noises arising during the day's work. It became necessary for the board of trustees to take some radical step in this matter. Noiseproofing was applied to the ceiling in the form of a nationally advertised cellulose preparation which could be painted without its usefulness being destroyed. This expedient was successful even though the walls were not so treated. Such a step is not inexpensive but is fully justified by the results obtained.

In the construction of a modern hospital the architect is wholly remiss if he does not provide for the control of noise. In many institutions, however, the control of troublesome noise does not concern itself entirely with that originating indoors, since the sounds arising from jangling street cars and honking motor cars are more annoying to patients than inside sounds. The control of extramural noise, however, becomes a civic matter in which the hospital administrator should take a prominent part.

## WHEN SHOULD A PUPIL NURSE BE COMPENSATED FOR INJURY?

Recently in a city hospital the eye of a pupil nurse became infected during a delivery, this organ later being destroyed. The pupil nurse in question hesitated to ask for compensation because she felt that it might be considered as an unfriendly act on the part of the hospital. On the other hand, however, the protection of the rights of just such persons is the reason for the existence of compensation laws and every institution should plan for its employees to receive fair play in this matter. The only party likely to originate an objection will be the insurance carrier. If disputes arise the hos-

pital should arraign itself upon the side of the nurse. On the other hand, if nurses were to seek compensation whenever an ankle is sprained or a finger infected, much trouble would be brought down upon the hospital and its administrator. This type of practice constitutes an abuse that should be discouraged. In the case of major incapacities, such as the loss of an eye or of a limb, which are likely to handicap the employee in making a living, the hospital should endeavor to obtain the relief the compensation law provides.

## WHAT DRUGS SHOULD BE ALLOWED FOR WARD PATIENTS?

Preparation of a formulary for use in the hospital is a necessary yet difficult step to bring about. The practice of hospital therapeutics appears to be in a chaotic state. Often the physician, wishing to appear fully acquainted with all of the up-to-date methods in medicine, is prone to prescribe new and expensive remedies for ward patients. The practice of such a policy would be relatively harmless if only one physician were so inclined, but when the use of expensive proprietary or semiproprietary drugs by several score of physicians is permitted, the waste of money becomes exorbitant.

To be sure, pharmaceutical houses provide many distasteful drugs, such as cod liver oil, for example, in palatable combinations. Such bottled goods, however, mount in price and while every hospital should certainly do what it can to make the stay of its patients comfortable, there appears to be a limit to which this attempt should go, particularly along lines of drug therapy.

Doctors' offices are flooded with attractive literature concerning new methods of administering iron, digitalis, pepsin and scores of other necessary drugs. However, the official formulary of the medical profession, the United States Pharmacopeia, certainly contains the names of a sufficient number of drugs to enable the physician to choose enough for the proper treatment of ward patients. Indeed in many institutions the drugs prescribed for this class of patients are confined to those listed in this volume. Many eminent physicians have remarked that if they were allowed to select a dozen drugs, they could satisfactorily treat a great



majority of their patients. The list of "New and Nonofficial Remedies" recognized by the American Medical Association contains a number of useful drugs many of which, however, remain unduly expensive. There appears to be no substitute for liver extract, for example, or for some other biologicals that are required daily. No restriction should be made upon this type of drug.

In most hospitals not possessing a formulary, there is no qualified person who may say that a drug listed in the United States Pharmacopeia should be substituted for the expensive one prescribed. The institution is justified, however, in insisting that this be done. The same may be said in regard to prescribing for dispensary patients. A careful inspection of all prescriptions emanating from the dispensary and from the wards should be made. By so doing, the institution will be able to save hundreds if not thousands of dollars annually on its drug bill.

The physician who insists on prescribing luminal instead of phenobarbital, or urotropine instead of hexamethylenamine is an expensive member of the hospital staff. The hospital administrator, if he is not medically trained, has a perfect right to, and should, require that the executive committee of the staff prepare a formulary, or if this does not appear feasible he should regulate the prescribing of drugs for ward patients. Exceptions may have to be made to this rule in the case of intravenous or other emergency medication, though this need seldom arises.

#### SHOULD THE SURGEON CHARGE FOR TREATING WARD PATIENTS?

This question is continually forcing itself upon the attention of hospital administrators. Its answer lies largely in local traditions and in the definition of the term ward patient. In some cities no more serious offense can be committed by a staff member than to charge a ward patient for professional services. In others, the institution permits such a practice provided it receives its full ward pay.

There are cases in which the ward pay fully covers the expense of treating the patient. In such instances it would be fair for the surgeon to charge a minimum fee for the treatment of the patient. When this practice is permitted, however, the hospital should be sure that it is not losing money on the treatment of such full pay ward patients, and it should also be given the right to supervise to some degree the size of the fee charged. In cases in which the full ward rate approximates \$3 a day, the hospital is likely to

lose money on every day's service rendered even to full pay patients. When this is the case the surgeon surely should not be permitted to charge a fee. It is probably best for full pay patients who are meeting the hospital cost to be treated in separate quarters from those who are being treated wholly or partially free. In the case of compensation patients for whose treatment the hospital receives its cost price the surgeon should be permitted to receive the fee allowed by law even though the patient is located in a ward area. Considerable confusion arises when an attempt is made to divide patients treated in the open ward into various economic classes. Whenever physicians are found to be obtaining money as a result of some private arrangement made with the ward patient before admission, the hospital should strongly rebuke such an action.

#### HOW LONG SHOULD A SICK PUPIL NURSE BE CARRIED ON THE PAYROLL?

There should be no practice of picayune policies on the part of the hospital when it comes to dealing fairly with graduate or pupil nurses who become ill while in the institution's employ. The business of nursing patients possesses many physical hazards. Nurses who contract an infection from patients for whom they are caring should certainly receive free treatment from the hospital and should be paid their salary for an indefinite period. It is different, however, in the case of pupil nurses who become ill on vacation.

Many hospitals have a definite policy that grants two or more weeks of sick leave with pay for each person who has been employed by the hospital longer than twelve months. Frequently an extension of this time is granted to persons who are particularly worthy or whose home conditions make impossible the provision of proper care. In instances in which the hospital admits a pupil nurse with an evident disability the institution takes upon itself the added obligation of caring for her should the ailment require hospitalization. This is an additional argument in favor of the careful physical inspection of every pupil nurse applicant as well as of every other employee in the hospital before employment. If the preliminary examination of all pupil nurses can be made thorough enough and if every preventive step can be taken that will avoid infection, the problem of reimbursing pupil nurses when they become ill will be reduced to a minimum.

Whatever the rule of the institution, a liberal attitude should be adopted with regard to the treatment of ailing pupil nurses.

## NURSING AND THE HOSPITAL

Conducted by M. HELENA McMILLAN, R.N.  
Director, School of Nursing, Presbyterian Hospital, Chicago

# Affiliate Courses and Advantages They Offer the Nurse

By MINNIE E. HOWE, R.N.  
Children's Memorial Hospital, Chicago

NURSING education is trending toward a sounder basis. The preferred course for student nurses is being selected with a view to giving the student maximum educational value in every subject incorporated in it. An important step toward this end is affiliation with hospitals that offer student nurses practical and theoretical instruction in fields not afforded by the home school. While such affiliations are already numerous, it seems that financial independence of schools of nursing would greatly increase their number as well as improve the conditions under which such courses are offered.

It is hard to anticipate what organization would result from a plan of wide affiliation or cooperation based solely on the needs of the students, but from the point of view of a principal of a special school, an independent central school seems possible. In such a school each hospital or health organization would offer under the direction of an independent executive body theoretical and practical experience, according to the requirements of the subject, in the special phase or phases of nursing that its facilities afforded.

With the exception of large medical centers connected with universities, few health organizations embrace all the essential departments necessary to give the complete practical and theoretical experience desirable for a well rounded course in nursing, and even schools meeting the minimum state requirements are often required to seek affiliation for their students.

Special hospitals affording advantages for student nurses and offering courses in a special field required for the general course in nursing have a definite twofold responsibility to nursing education: (1) to supply for student nurses the

special course that cannot be satisfactorily given in their home school; (2) to select for affiliation schools maintaining standards of nursing education that liberally meet the needs.

To decide when to negotiate an affiliation is one of the greatest problems of a special school. Frequently schools are compelled to seek affiliation in order to meet minimum state requirements. While meeting these requirements in all subjects but the one for which they desire to affiliate they may be failing to meet satisfactorily the necessary higher standards, such as are outlined by the National League of Nursing Education or suggested by the results of the recent studies of the Committee on the Grading of Nursing Schools. In many cases the affiliation is sought not primarily to broaden the student's program but to keep a school in existence for the purpose of providing a nursing service for a hospital that cannot support a graduate nursing service. Thus careful investigation is necessary before an affiliation is extended to a school. By lenience in accepting questionable schools for affiliation, the special school may assist in increasing the numbers of poorly prepared nurses graduated into an already overcrowded and underprepared profession.

On the other hand, affiliation for a good course in one of the basic subjects of nursing strengthens the nurse's preparation, and schools of high standards offering satisfactory educational advantages but limited in certain special subjects merit cooperation from the school that can supply the needed courses.

The standards for accrediting schools of nursing vary so widely that it is necessary for the special school to set up its own matriculation requirements. These requirements are affected (1)

by the type of nursing service the special hospital wishes to maintain for the care of its patients, (2) by the quality of the teaching and supervising done in the special hospital and (3) by the standards of the institution and the quality of the work done by it as a whole.

#### *What Affiliate Schools Require and Offer*

All hospitals accepting students for practical experience in nursing are dependent upon these students to supplement the hospital nursing service to a greater or lesser degree. Therefore the standards of the schools supplying students for affiliation must be acceptable to the school receiving the students. Such standards should be high enough to allow the student to present herself for her affiliation term with a sound knowledge of nursing fundamentals plus that of the special services and courses necessary for a background for the affiliation course. In general, the students must be physically and mentally equipped to adjust themselves to the new environment.

In turn, the special school should offer to the affiliating student a course arranged to give the maximum educational advantages afforded by the special hospital. This should be limited only so far as to exclude material not considered essential for the student's education. While these courses should always meet the standards set up by the state board of examiners, no school that is justified in offering affiliation for a special subject should content itself with giving the minimum course.

The agreement of affiliation effected between schools should attempt to cover all essential points affecting the course to be given, the control of the students and the obligations of the two schools entering into the agreement. It should specify the length of the affiliation period, the number of students to be received by the special school, the instruction the students are to receive, the records to be supplied by both schools, expenses to be incurred, care in event of illness, control of extra curricular activities and conditions under which the affiliation is cancelled.

Affiliation for students in a special hospital that does not maintain an independent school may be under essentially different conditions from that in a general hospital that accepts students for affiliation in special subjects in connection with their general school.

One outstanding difference is that the first has no students other than the short-term students. This makes it necessary for the special hospital to have a permanent graduate nursing service. This staff should consist of well prepared instructors, supervisors, head nurses, bedside nurses

and nurses assigned to special routine services. The proportion of graduates to students may vary according to the needs of the hospital. The Children's Memorial Hospital, Chicago, with a service of approximately 200 patients and a nursing staff of 115 to 120 nurses, has maintained a fairly satisfactory nursing service in connection with its school, with an average proportion of five graduates to seven students. We believe that a more ideal plan could be worked out on a one-to-one basis, that is, one graduate to one student. This estimate does not imply that the size of a school should depend upon the size of the graduate nursing staff. It suggests that under similar conditions an increase in the relative number of graduate nurses is desirable for stabilization of service and instruction and supervision of students.

Further stabilization of the nursing service should be ensured by avoiding too many new students on the wards at one time. This may be accomplished by dividing the affiliating students into two groups and alternating their entrance dates. With this method, at any given time approximately half of the students will have been in the school the maximum length of time that can be arranged with a short-term course.

In special hospitals where larger graduate nursing staffs and smaller student bodies in proportion to patients are maintained, there is an advantage in a less frequent entrance of classes, as it simplifies the teaching program, particularly the lectures. Under such circumstances, the classes are best entered on a complete exchange basis. This plan has been successful in the school conducted by the Children's Hospital, Cincinnati. All the students in the school enter at the same time and are replaced by a new group when they have completed their course. A plan of this kind would probably find greater favor with the home school, as students would not have to be sent away for affiliation at such frequent intervals.

#### *Affiliation at Children's Memorial*

The school of pediatric nursing of the Children's Memorial Hospital conducts a short course planned to give student nurses one of the four major courses required in all schools of nursing in the United States. The length of the course is four months, one month in excess of what is required by most state boards. While three months may be considered adequate under certain conditions, we find that a longer period is advisable, as the student is required to make a complete readjustment in her new environment. Further, we are able to give instruction in services included in the basic course for nurses in addition to the





For the benefit of those who use Bard-Parker knives, the Bard-Parker Company has perfected a highly efficient distribution system. The hospital is assured of a dependable source of supply, sufficient at all times to meet every emergency. All dealer stocks of Bard-Parker knives and blades are of the same high quality and uniformly priced.

**Prices:** Bard-Parker handles—\$1.00 each. Blades, six of one size per package—\$1.50 per dozen.

**Quantity Discounts:** 1 to 5 gross, all sizes of blades, unit delivery—10% discount. 5 gross or more, all sizes of blades, unit delivery—15% discount.

**BARD-PARKER COMPANY, INC.**  
369 Lexington Avenue, New York, N. Y.

A BARD-PARKER PRODUCT

*It's Sharp*

usual subject matter required for a satisfactory course in pediatrics. This includes orthopedics and experience in a large and active out-patient department, embracing extensive work done under the direction of a well organized social service department. Most of the schools applying to us for affiliation are in need of the courses afforded by these services.

While the length of the affiliation period may not be limited to the minimum state requirements, it should not involve a waste of the student's time by repetition of subject matter given in the home school or by including nonessential material in the course.

#### *How Cook County's Program Functions*

In one of our large Middle Western schools, the Cook County School of Nursing, Chicago, where affiliation courses are made a part of the regular program, the shortest affiliation period is four and one-half months. While the student is not required to spend more time in any department than is needed to meet the particular needs of her course, it is not deemed advisable by this school to enter students for too brief a period. One popular course offered allows three months for pediatrics and six weeks for medical diseases in adults. This combination of courses is arranged to cover a common deficiency in the services of many general hospitals.

The curriculum in the Children's Memorial Hospital school of pediatric nursing is planned to correlate with the entrance of each group. Classes are repeated every two months or are given six times a year. Although this frequent repetition involves a heavy teaching program, it has its advantages in that it stimulates constant teaching and supervising by the graduate group. No member of the graduate staff is free from the responsibility of supervising the students. It strengthens the student's position as a student and the graduate nurse's position as her adviser.

The success of an affiliate school is highly dependent upon the cooperation it receives from the schools that supply it with students. Regular meetings of the principals are vitally necessary. The special school is analogous to one of the departments of a general hospital and a close relationship is required for desirable results. All the policies of the special school must be worked out in agreement with those of the many general schools. This necessity is readily illustrated by difficulties that arise in the special schools in regard to: standardization of fundamental procedures in nursing; health examinations and positive health treatment for students received for affiliation; the interference of home class work during

the affiliation period; the elimination of students who fail during the affiliation period.

The problems arising from the lack of uniformity of technique in schools of nursing are especially acute in the school receiving affiliate students. While it is readily recognized that it would not be possible or desirable to establish identical techniques in all types of institutions, the fundamentals of the care of patients are much the same under all conditions. It is not what might be called the trimmings of a procedure that prove fatal when a group of students of varying backgrounds assemble for a given course. It is the lack of knowledge of fundamental principles of nursing.

Take the giving of a bath, for example. State the objective as "to cleanse the patient, endeavoring to leave him in as good condition mentally and physically, if not better, at the end of the treatment as at the beginning." Are not the principles involved in accomplishing this result the same in any situation? To find a nurse giving a bath with two inches of water in the bottom of an eight-quart basin with the floating soap barely visible in the heavy lather that she is applying to the skin of the patient, is not necessarily the result of difference in equipment set-ups. The presence of a lavatory supplying running water in the room does not seem to alter the procedure. Again, the proper cleansing of a clinical thermometer should not cause difficulty in a new environment. However, we have found that it frequently does; and the seriousness of such a difficulty is that the nurse has failed to appreciate the necessity of cleanliness in connection with disinfection.

#### *Establishing a Universal Technique*

In a paper discussing "The Responsibilities and Problems of the School Receiving Affiliating Students," presented by Marion Rottman at the biennial convention of the national nursing groups held at Milwaukee in 1930, the problem of standards of work and uniformity of methods was discussed. Miss Rottman stated that attempts to solve the problem of difference in methods in the Bellevue Hospital school of nursing, New York City, which averages a turnover of 250 affiliating students a year, led the schools affiliating with Bellevue for special courses to adopt the Bellevue technique and methods. This accomplishment at Bellevue seems to indicate the possibility of establishing a universal technique in many types of institutions, for while we are not familiar with the institutions represented in this affiliation, we know that the working conditions in few institutions are similar and that if it was possible successfully to standardize techniques and methods in



GERMICIDAL TEST IN WORLD  
FAMOUS LABORATORY PROVES

# LYSOL...NOW

With characteristic thoroughness, "Lysol" chemists called on the staff of a great laboratory to check their phenomenal findings for the new double-strength "Lysol" disinfectant.

In a standard germicidal test, conclusive proof was secured that a "Lysol" had been created that is twice as quick in killing such pathogenic organisms as bacillus typhosus.

The phenol coefficient of "Lysol" is now 5, while ordinary cresylic preparations, as a rule, give one-half or less of this value. This new double-strength "Lysol" not only opens up great new possibilities in the field of modern antisepsis . . . but it brings to hospitals for the first time a disinfectant that assures a maximum safety with a minimum disinfection cost.

Double-strength "Lysol" is available to hospitals at the same no-profit-price that prevailed on the old "Lysol" . . . \$1.50 a gallon in lots of ten gallons or more. Get your order in early . . . Use the coupon.

**TWICE AS STRONG**  
... in phenol coefficient

**TWICE AS QUICK**  
... in germicidal action

**BUT SAME  
PRICE PREVAILS**  
\$1.50 PER GALLON in lots of 10  
gallons or more



*Lysol*  
Disinfectant  
REG. U.S. PAT. OFF.

LEHN & FINK, Inc.  
Hospital Dept. M-7  
Bloomfield, N. J.

Will you kindly ship immediately  
. . . gallons of the new double-strength  
"Lysol" disinfectant.

Your name and title \_\_\_\_\_

Your hospital \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_



this group of institutions, it is because the basic principles of the procedures are everywhere the same.

The physical condition of the students reporting for an affiliation term in another school should be given careful consideration. It is commonly recognized that individuals going from one locality to another often suffer changes in health. We have found this demonstrated by our students coming from small communities to the city. Often they are with us only a short time before some unexpected ailment develops, usually either of an infectious nature or as the result of a latent condition that has not recently been active. This observation has been further confirmed in our school by the lack of illness in a group of students who come to us for affiliation from a neighboring hospital only a few blocks away. For several years the illness rate among these students has been lower than that of any other group coming from any one school, despite the fact that the near-by school sends us the largest number of students.

Health hazards may be further increased by the type of service for which the student wishes to affiliate, for example, communicable diseases and pediatrics, subjects that are commonly given through affiliation. A complete physical examination with a check on all phases of the student's health as well as specific prophylactic treatment for all communicable diseases is as essential for the student's preparation for an affiliation period as it is for her entrance into the general hospital for her preliminary term.

#### *Students' Health—A First Consideration*

Further, it is the responsibility of the school receiving affiliate students to safeguard their health during the affiliation period. The permanent health service of the Children's Memorial Hospital has largely been the outgrowth of the needs of our affiliate school. A full-time nurse employed as health and social director, working under the direction of a part-time health physician, has made it possible for us to outline a program for our students. The health physician has full responsibility in health questions. No resident or intern is obliged to devote endless hours to the treatment of the personnel. This has a definite advantage in fixing responsibility and in controlling medical advice given to the personnel. Positive health habits are stressed, and social and recreational activities that have mental and physical hygienic value are sponsored. Despite the fact that this department has been under organized heads slightly more than one year, it has greatly increased the efficiency with which we are able to handle health and illness problems.

We are often asked to relate our experience with the problem of the interference of home class work during the period of the student's special course. The success of an affiliation term is easily jeopardized if home class work is allowed to interfere. If the affiliation period is properly planned, it will require the best efforts of the average student. In addition to the course outlined, the students are faced with the problem of adjusting themselves in a new situation. While the changed environment often proves to be stimulating and affords a new interest in the otherwise lagging senior year, it requires full attention and it is the exceptional student who can benefit from demands made of her that necessitate divided attention.

#### *Planning for Affiliation*

In reply to a questionnaire sent out to our affiliate schools as to how they plan their educational program so that their students are free for our affiliation period, the following information was received. A large number of the schools give all their class work connected with the general course in the first two years, leaving the last year free for affiliations and electives. Other schools give all their class work in two and a half years. All schools that give some class work in the third year repeat their courses twice each year. Some stated that the repetition was given to provide for the affiliation program and others that it was necessary to repeat courses for other reasons, so that affiliation did not affect their program. One school reported that intermediate and senior students were divided and half of each group given classes together in order to make the rotating affiliate term possible.

The problem of permanently eliminating students who fail in their work during an affiliation period requires careful cooperation of the affiliating schools.

The affiliation period is often an acid test of the student's general ability. Most affiliations are arranged in the latter part of the student's course, often coming in her senior year. As has already been stated, complete readjustment to a new situation is necessary. Since the student must make satisfactory adjustments when she is a graduate nurse, is it not necessary to measure her adjustment in the affiliate school carefully?

It is generally agreed that unsatisfactory student nurse material should be eliminated as early in the course as possible. The preliminary term is set aside to measure the student's aptitudes, and if undesirable applicants get into the school this is the preferred time to eliminate them. Nevertheless, it is frequently evident that



# BEWARE of these two little words!

Low price is a weighty argument in favor of any purchase. But low price is often confused with cheapness. And a cheap piece of goods is never a bargain. Obvious? In these days one often overlooks the obvious. Remember, challenge every product that is abnormally low priced. When all you can say for it is that it doesn't cost much, don't buy it!

*Ideal*  
Food Conveyor Systems

Manufactured by  
THE SWARTZBAUGH MFG. COMPANY  
TOLEDO, OHIO

The Ideal Food Conveyor System is the lowest priced meal distribution method a hospital can employ. Low price is the result of low production cost despite the superior design, construction, workmanship and the high quality of materials used in Ideals. Ask to have your meal distribution needs appraised and specifications submitted. No cost to you for this service.



*Every hospital superintendent, every member of the board, every executive should read this little book. We will be glad to send gratis sufficient copies to your hospital. Write for them.*

schools are confronted with the problem of dropping students later in their course. Despite the fact that schools are being forcefully urged to select their students carefully, it is no uncommon occurrence for them to have students in their senior classes who have been doing consistently inferior work. In 1930 we awarded 185 certificates and dropped fourteen students for unfitness. The reasons for the fourteen dismissals were poor health, unsatisfactory work or misconduct. None of these conditions were new developments acquired during the affiliation period.

The history of the students dismissed because of poor health dated back to previous conditions. In each case it was deemed advisable by the special school and the home schools to terminate the courses of these students. Solving the problem of disposing of students with serious health conditions seems to be easily agreed upon once it is made evident.

Misbehavior of students can often be handled with satisfactory results. Violation of ethics or social standards is not widely varied in its interpretation, in spite of the fact that certain recent changes have occurred in our general opinions. It is interesting to note that in some instances the special school may be of assistance to the home school in student management problems. Often the special school is in a more independent position than the general school. A recent incident illustrates this point. A young woman came to us from one of our associate schools and started her term of affiliation for pediatrics. Scarcely a month had passed before she was well known in the school by all who came in contact with her. She had a deliberate, challenging manner that indicated she expected to conduct herself in a fashion largely suited to her own wishes. Before long she had placed herself in a position where she was subject for dismissal. When the home school was notified of the incident, those in charge were not surprised that the young woman was in trouble and heartily welcomed our recommendation that she be dropped. They had been compelled to keep her in their school because she was the niece of one of their prominent staff doctors. Previously, every time the young woman had been criticized she had been exonerated. With our help the home school was able to terminate her course.

#### *Helping the Nurse to Achieve Success*

The problem of the quality of the work of students is more complex. It seems evident that if all the care were exercised that should be in selecting and guiding student nurses to their senior year, the result would be a group of young women who could pass a properly planned course

without failure and that repetition of courses would be unnecessary. We feel that such a standard is not too high for the special school. Repetition of courses and elimination of unqualified students should not be the job of the short-term school.

#### *Evaluating the Nurse's Ability*

It can readily be seen that a satisfactory evaluation of the student's ability may not be gained until her affiliation period is nearly completed. This presents an unpleasant situation and requires cooperation from a school that perhaps has already been too lenient with the student. Nevertheless, it seems to be the definite responsibility of the principal of every school, special or general, to use her influence to eliminate any student nurse at any period of her course who is not measuring up to the standards required by the needs of the profession. Such action must be based on individual investigation of each case. Too often such investigation reveals the fact that the student's work has been consistently inferior or that definite shortcomings have evidenced themselves before. Our experience has shown that a high percentage of nurses react favorably to affiliate courses. While successful adjustment of students may be delayed in some instances, we have no records of students failing in affiliate courses who have not been doing a questionable quality of work in the home school.

We are not in need of a large supply of nurses; we are in need of highly qualified women with a liberal nursing education. We are not in need of large schools; we are in need of schools where highly qualified young women may receive an education in the art of nursing that will meet the strenuous demands of the profession.

The outstanding advantages of an affiliate course may be summed up as follows: (1) it supplies subject matter that should be included in the basic course for nurses, which cannot be given by the home school; (2) it broadens the student's experience; (3) it offers the student a timely stimulation, usually being arranged in the senior year when interest may be lagging; (4) it supplies a test for the student's adaptability, before it is too late to discover that this essential quality is lacking.

Lastly, special courses given on a cooperative or affiliate basis in the institutions offering the greatest opportunity in the subjects involved suggest a plan for the organization of an independent school of nursing, affording maximum advantages.<sup>1</sup>

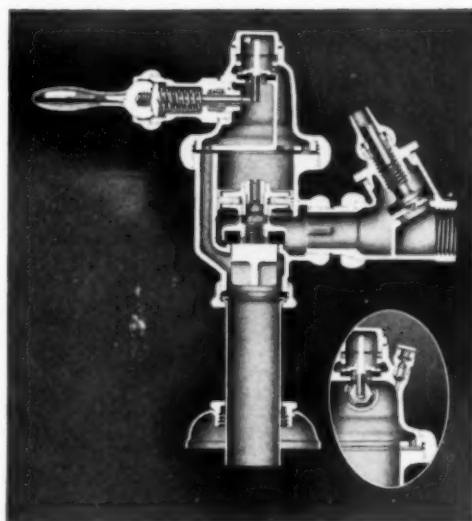
<sup>1</sup>Read at a meeting of the midwest division of the American Nurses' Association, Des Moines, Iowa.





# Again Crane *leads the field*

THE American Society of Sanitary Engineers issue a warning of danger in the use of plumbing fixtures which permit the possibility of water pollution through back-siphonage of waste into the water supply system. At a meeting recently held in Washington, D. C., committees were appointed to devise ways and means of protecting the populace against this danger.



*Crane vacuum-breaker valve which eliminates the pollution of fresh water lines by back-siphonage*

Several years ago it was observed by noted health authorities that in some of the country's most famous hospitals, in spite of all precautions, post-operative infections were occurring and water-borne diseases were spreading. Crane Co. collaborated with medical authorities, and their engineers set out to learn the cause and devise a remedy.

The first definite results were found when it was proved that a partial vacuum created in the water supply system, due to a drop in pressure, drew polluted water from waste lines into the water supply. Further research showed the

condition was common; at many points fresh water lines were subject to pollution by siphonic action through the valves of such fixtures as closets, slop sinks, baths, lavatories, fountains, and aspirators.

To overcome this, Crane engineers worked out a line of vacuum-breaker valves which eliminate all danger of back-siphonage.

So successfully have Crane engineers applied this principle to all fixture valves where back-siphonage threatens, and extended it by raising the spouts of lavatories, baths and drinking fountains, that progressive Health Departments now insist hospitals and institutions use only such fixtures and valves as adequately guard against back-siphonage. You can see these materials at your Crane Exhibit Rooms, or get full information concerning them by writing Crane Co.



CRANE CO., GENERAL OFFICES:

836 SOUTH MICHIGAN AVENUE, CHICAGO, ILLINOIS  
NEW YORK: 23 W. 44TH STREET

*Branches and Sales Offices in One Hundred and Seventy Cities*

# CRANE

## NEWS OF THE MONTH

## Four States of Mid-West Join in Practical Program

**A**N EXCELLENT, practical program featured the sixth annual meeting of the Mid-West Hospital Association which was held in St. Louis, June 2 and 3. Representatives from the states of Colorado, Kansas, Missouri and Oklahoma were present, and the first session was opened with E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, president of the Mid-West association, presiding.

Following invocation by the Rev. F. P. Jens, superintendent, Evangelical Deaconess Hospital, St. Louis, greetings were given by the Rev. Rufus D. S. Putney, superintendent, St. Luke's Hospital, St. Louis. Doctor Putney stressed strongly the note of optimism which should be followed in these days of stress.

Dr. B. A. Wilkes, consultant for Baptist hospitals in Missouri, was the next speaker and made some suggestions for meeting the present economic conditions. His remarks were most constructive and a general discussion ensued.

On Thursday afternoon, Frank J. Walter, president of the Colorado Hospital Association, and superintendent, St. Luke's Hospital, Denver, presided. Dr. Bert W. Caldwell, executive secretary, American Hospital Association, gave a summary of the state laws affecting hospitals and also explained the geographic membership of the American Hospital Association.

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, spoke on the qualifications and responsibilities of a record librarian, and J. P. Jacobs, credit manager, Missouri Baptist Hospital, St. Louis, told of a movement for the cooperative collection of hospital accounts in St. Louis.

A reception, banquet and dance were held on Thursday evening with Miss Anscombe acting as toastmistress. Many guests were introduced and many musical numbers were presented. The address of the evening was given by C. Rufus Rorem, Ph.D., associate for medical services, Julius Rosenwald Fund, Chicago.

Dr. B. A. Wilkes presided on Friday morning. The first speaker was President Paul H. Fesler of the American Hospital Association who told what the association was doing for its members and requested the cooperation of the state groups in the hospitalization of veterans in civil hospitals, a matter now under consideration.

The second paper was given by Matthew O. Foley, editorial director, *Hospital Management*, on the importance of a survey preliminary to a building program. This was discussed by H. C. Smith, business manager, University of Oklahoma Hospitals, Oklahoma City, Okla.

The third paper was "The Responsibilities of Boards of Trustees," presented by John A. McNamara, executive editor, *THE MODERN HOSPITAL*. This paper was discussed by Mr. Fesler, Doctor MacEachern, Dr. William H. Walsh, Chicago, Miss Anscombe and several others.

The other papers of the morning were given over to nursing and food service. An excellent round table was held in the afternoon by Doctor MacEachern and a report of the committee on resolutions and recommendations was presented by John R. Smiley, superintendent, St. Luke's Hospital, Kansas City, Mo.

At the conclusion of the meeting it was announced that George W. Miller, manager, Morning-side Hospital, Tulsa, Okla., had been named president-elect of the association. Miss Anscombe then turned over the meeting to Mr. Smiley who becomes president for the ensuing year.

### New Hospital Will Honor Pioneer North Carolina Physician

Brevard, N. C., the land of waterfalls, is soon to have a new hospital, a memorial to a pioneer physician of that section, Dr. Andrew J. Lyday. The hospital will be known as the Lyday Memorial Hospital. A son, Dr. W. M. Lyday, is equipping a ward containing twelve beds in the new hospital.

# ELI LILLY AND COMPANY

FOUNDED 1876

Makers of Medicinal Products  
for Use Exclusively  
Under Professional Direction



## MERTHIOLATE

An organic mercurial germicide distinctive for its combined germicidal value and tissue compatibility. Supplied in a variety of convenient forms.

*Prompt Attention Given to Physicians' Inquiries*  
*Address Principal Offices and Laboratories, Indianapolis*



## NEWS OF THE MONTH (Cont'd)

## National Nursing Groups Appeal to Hospital Trustees

**A**ID in stemming the increasing stream of nursing school graduates is asked of hospital trustees throughout the United States by organized nursing in an open letter recently posted. The letter bears the signatures of the presidents of the American Nurses' Association, the National League of Nursing Education, the National Organization for Public Health Nursing and of the chairman of the committee on distribution of nursing service of the A. N. A.

Five ways in which hospitals may balance the extra cost involved in employing larger numbers of graduate nurses are enumerated in the letter, following a brief picture of present overcrowding in the nursing profession. Further suggestions are sought from the hospital trustees.

"The broken morale of thousands of unemployed nurses has begun to react most unfavorably not only on the number of young women applying but on the quality of applicants for enrollment in schools of nursing," says the letter. "This will inevitably increase when economic conditions improve unless the interested groups—hospitals, doctors and nurses—take effective action."

### *Prompt Action Is Needed*

The best thought of all groups concerned will be needed to work out the adjustments in nursing service that the next few years will require, the letter points out. But certain steps can be taken now, it contends, to help tide the nurses over the present crisis without adding to the financial embarrassment of the hospitals. These steps will also provide a sound basis for future development, it is believed.

The nurses' suggestions for the present are as follows:

1. Better selection of students, thus cutting down the cost of carrying large numbers of probationers for several months only to eliminate from 25 to 50 per cent of them.

2. Employment of ward helpers, maids, orderlies, attendants and secretaries to do a large amount of the routine work done by students.

3. Strengthening of hospital organization by the employment of graduate nurses who are available at relatively low salaries, thus giving the doctors nursing service uninterrupted by class attendance and the patients the care of more experienced nurses.

4. Tuition fees for students in schools offering a sound and well organized teaching program; also use of facilities of near-by educational institutions to save part of the cost.

5. Abolishment of allowances and use of the funds for teaching the students.

"The nurses' problem is due not chiefly to the economic depression but to the weakness of a system of accepting students primarily as workers in the hospital instead of selecting them as potential graduates for service in their community in the various types of nursing," the letter concludes.

## Connecticut Historians Hold Annual Meeting

The annual meeting of the Connecticut Hospital Historians' Association was held at the Stamford Hospital, Stamford, on the afternoon of May 21. Thirty-five members of the association attended the meeting.

The officers elected for the ensuing year are as follows: president, M. Beatrice O'Connell, St. Francis Hospital, Hartford; vice-president, Grace E. Gillespie, Stamford Hospital, Stamford; secretary and treasurer, Anna M. Kelly, William W. Backus Hospital, Norwich.

After the business meeting, three papers were presented by members of the Stamford Hospital staff, Dr. Edmund J. O'Shaughnessy, whose subject was "Charts," Dr. Addison H. Bissell, who spoke on hospital records, and Dr. Frank M. Harrison, who discussed the value of records.

After the papers, supper was served in the nurses' recreation room.

# AMERICAN



**F**OR particular requirements in fields of architecture, engineering, construction, refining, chemistry, food handling, machinery and equipment—and for practically endless uses in industry, store and home, USS STAINLESS Steel Sheets, and fabrications made from them, can be made to render the maximum of endurance combined with beauty and utility. No one metal or alloy is altogether corrosion-proof in all applications, but different metals and alloys have shown marked immunity under varying conditions—both chemically and physically.

Through extended research the subsidiary companies of the United States Steel Corporation have developed and offer Stainless Steels that are specially adapted for modern uses. The world-famous processes of the Krupp interests in Germany have also been made available by special arrangement.

Chromium-Alloy Steels Ferritic	Chromium-Nickel Steels Austenitic
USS 12	USS 18-8
USS 17	USS 18-12
USS 27	USS 25-12

Our metallurgists are at your service and will gladly assist you in selecting the grade of Stainless Steel Sheets or Light Plates most suitable to your requirements. Send for literature. This Company also manufactures high grade Sheet and Tin Mill Products adapted to all known purposes.

*USS Chromium-Nickel Alloy Steels produced under licenses of the Chemical Foundation, Inc., New York; and of Fried. Krupp A. G., of Germany.*



## American Sheet and Tin Plate Company

General Offices: Frick Building, Pittsburgh, Pa.

SUBSIDIARY OF UNITED STATES STEEL CORPORATION



AMERICAN BRIDGE COMPANY  
AMERICAN SHEET AND TIN PLATE COMPANY  
AMERICAN STEEL & WIRE COMPANY  
CARNEGIE STEEL COMPANY

PRINCIPAL SUBSIDIARY MANUFACTURING COMPANIES:  
COLUMBIA STEEL COMPANY  
CYCLOPE FENCE COMPANY  
FEDERAL SHIPYARD & DRY DOCK CO.

ILLINOIS STEEL COMPANY  
MINNESOTA STEEL COMPANY  
NATIONAL TUBE COMPANY

OIL WELL SUPPLY COMPANY  
THE LORAIN STEEL COMPANY  
TENNESSEE COAL, IRON & R.R. COMPANY  
UNIVERSAL ATLAS CEMENT COMPANY

*Pacific Coast Distributors—Columbia Steel Company, San Francisco, Calif.*

*Expert Distributors—United States Steel Products Company, New York, N. Y.*

## NEWS OF THE MONTH (Cont'd)

## Social Workers Consider Pressing Problems at Annual Meeting

MEDICAL social workers from the United States and Canada met at the annual meeting of the American Association of Hospital Social Workers, held in Philadelphia, May 15 to 21, in conjunction with the National Conference of Social Work. Forming a small section of the 4,000 social workers who attended the general conference, some three hundred in the medical field met in special sessions to consider some of the important subjects which this group as a special field must meet. Henri-Ette Kirch, director of social work, Graduate Hospital, University of Pennsylvania, was in charge of this program.

The meeting opened with the general business meeting of the association. Reports of the committees and the officers were given. Edith Epler, director of social work, Syracuse Free Dispensary, Syracuse, N. Y., reported on the findings of a committee which has been working for three years on the administrative organization of the association. Elizabeth Gardiner, assistant professor of sociology, University of Minnesota, reported for the case competition committee, one of the valuable original contributions which the association has made to social work and especially in its own field. Agnes Schroeder, Western Reserve University, Cleveland, reported on the "Plan for Statistics in the Field of Medical Social Work," a handbook in a limited edition now available from the office of the Children's Bureau, Washington, D. C.

Dr. Elizabeth Wisner, Tulane University, New Orleans, president of the association, gave a sound and inspirational address to the membership pointing out clearly the responsibilities of professional groups for the ever increasing obligations that modern society demands.

Helen Beckley, executive secretary, presented the annual report, pointing out some of the trends of the field as reflected from the headquarters office.

The report of the educational secretary, Kate McMahon, Simmons School of Social Work, Boston, described the introduction of medical social education to the curriculum of the graduate school of

social work, University of California. This represents the eleventh school of social work to include in its program opportunities for the education of social workers planning to enter the field of medical social work.

The first general program meeting was held on Tuesday afternoon, May 17. Dr. Earl D. Bond, director, Institute of Mental Hygiene, Philadelphia, presided. Edith Kruckenberg, director of medical social work, Pennsylvania School of Social and Health Work, read a paper on social treatment.

### *Miss Gardiner Becomes President*

The high point of the program was reached on Thursday night when at the annual dinner meeting, Dr. Esther Loring Richards, Johns Hopkins Hospital, Baltimore, gave a stirring talk on "Practical Objectives in Hospital Social Work." Doctor Richards pointed out in no uncertain terms the weaknesses and the strengths of the present practitioners of social work as she knows them. The importance of a better and more skillful use of the knowledge of the social worker and the shortening of the gaps between social worker and physician were pointed out. Some of the inadequacies of certain tools of practice such as recording were presented. She also made many practical suggestions for a closer relationship between the hospital and the other community social agencies through the more professional contacts of the social workers. Ida M. Cannon, Massachusetts General Hospital, Boston, told briefly of her plans to discuss medical social work on the program of the International Conference of Social Work to be held in Frankfurt, Germany, in July. The meeting was closed by the new president, Elizabeth Gardiner.

The general meeting on Friday, May 20, brought to the membership one of the most valuable and comprehensive reports the association has ever had. This year the case competition committee studied the award and honorable mention cases submitted since the beginning of the competition in 1925. Twenty-seven cases were reviewed and analyzed by the committee.



## LOS ANGELES COUNTY GENERAL HOSPITAL » ACUTE UNIT



*Equipped with more than Thirteen Hundred*  
**SLOAN FLUSH VALVES**

**ALLIED ARCHITECTS ASSOCIATION  
OF LOS ANGELES**

Edwin Bergstrom, Myron Hunt, Pierpont Davis,  
Sumner P. Hunt and William Richards, *Directors*

*Plumbing Supply Jobber:*

**CRANE CO., Los Angeles**

*Plumbing Contractors:*

**HOWE BROS., Los Angeles**



---

**SLOAN VALVE CO. CHICAGO**

---

## NEWS OF THE MONTH (Cont'd)

## Minnesota Association Meets With State Medical Group

J. G. Norby, superintendent, Fairview Hospital, Minneapolis, was named president-elect and Dr. Charles Remy, superintendent, Minneapolis General Hospital, was elected a vice-president at the annual meeting of the Minnesota Hospital Association, May 23 and 24, held in conjunction with the annual Minnesota State Medical Association convention in St. Paul.

James McNee, superintendent, St. Luke's Hospital, Duluth, is the president for the current year, succeeding Dr. Fred G. Carter, superintendent, Ancker Hospital, St. Paul. A. M. Calvin, executive secretary, Midway and Mound Park Hospitals, St. Paul, is the secretary-treasurer.

The meeting was successful from both the standpoint of attendance and the timeliness of the subjects discussed. "Economy" and "Hospital Management" were discussed freely in all sessions of the various round table conferences and were included in the papers presented.

At the joint meeting with the medical association, "Medical Hospitals in the Care of Veterans," was the main topic discussed. Speakers on this program included: Paul Fesler, president, American Hospital Association; A. E. Fitzpatrick, dean, Marquette University; Dr. Morris Fishbein, editor, *Journal of the American Medical Association*; E. V. Cliff, member of the national executive committee, American Legion, and F. T. Bigelow, hospital trustee.

## Gen. Frank T. Hines Is Chief Speaker at Alabama Meeting

Gen. Frank T. Hines, director, Veterans' Bureau Administration, was the guest of honor and chief speaker at the spring meeting of the Alabama Hospital Association, Birmingham, May 22.

Hospital executives and other prominent persons from all over the state were present and greetings were sent from other state associations.

Round table discussions directed by W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg, Miss., were enthusiastically entered into by the members.

In the afternoon, Dr. S. R. McPheters, Alabama Department of Health, spoke on the state's tuberculosis program and what it hopes to accomplish by its traveling tuberculosis clinics. She also discussed the new state law that authorizes a county to build sanatoriums for the care of its tuberculous patients, with a fee of \$1 per capita to be paid by the state.

Dr. French H. Craddock, Sylacauga, told of his plans to visit as many of the hospitals as possible before the fall meeting. The secretary, Bertha McElderry, Talladega, was chairman of the entire program.

## Baltimore City Hospitals Start Work on New Unit

Construction work has started on the new \$847,000 general hospital unit of the Baltimore City Hospitals, Baltimore.

The new unit will provide 410 beds.

The new hospital will rank second in size only to Johns Hopkins Hospital among the hospitals of the city. A tuberculosis hospital and an addition to Ward A, the general building, are to be built out of \$452,311 saved by the city out of the \$1,300,000 allotment made for the general hospital unit.

## Coming Meetings

### American College of Surgeons.

President, Dr. Allen B. Kanavel, 54 East Erie Street, Chicago.

Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.

Next meeting, St. Louis, October 17-21.

### American Hospital Association.

President, Paul H. Fesler, Wesley Memorial Hospital, Chicago.

Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.

Next meeting, Detroit, September 12-16.

### American Protestant Hospital Association.

President, Rev. A. O. Fonkalsrud, Mansfield General Hospital, Mansfield, Ohio.

Executive secretary, Dr. Frank C. English, Hyde Park, Station O, Cincinnati.

Next meeting, Detroit, September 9-12.

### Association of Record Librarians of North America.

President, Maurine Wilson, Ravenswood Hospital, Chicago.

Secretary, Betty Gray, Nassau Hospital, Mineola, N. Y.

Next meeting, Detroit, September 12.

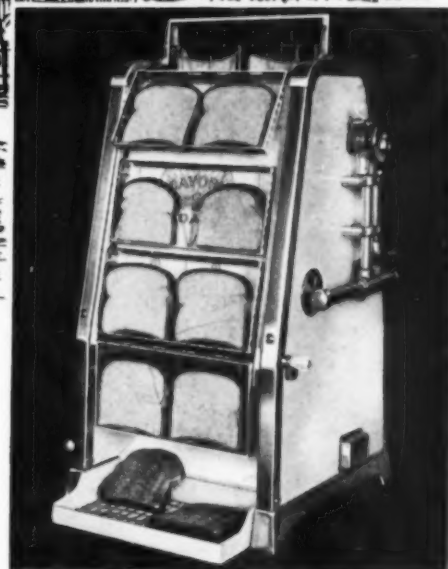
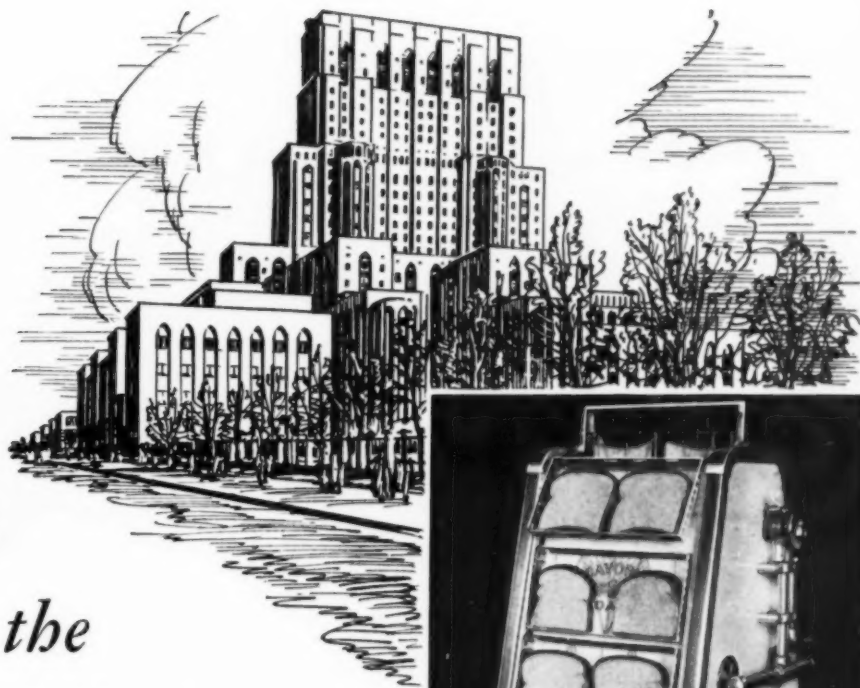
# SAVORY TOASTERS

*exclusively for the  
Cornell Medical Center*

YOU can be sure that every piece of equipment in the new Cornell Medical Center has been selected with infinite care. No wonder, then, that you'll find it equipped throughout with Savory *radiant gas* Toasters. Here is further proof of the fact that a majority of new hospitals are installing more Savory Toasters than all other kinds.

## BETTER TOAST AT LOWER COST

Savory toast is different—decidedly better, say dietitians. Because the bread is first cooked with moisture-bearing heat—that imparts the appetizing soft center. Then *radiant* heat caramelizes the sugar on the surface of the bread, making delectable, crisp toast that's more easily digested. Coupled with a definite improvement in quality of the toast is superior ease of operation. The nurse need only place one slice or two dozen in the baskets traveling up the front of the toaster. Then she can get the rest of the food for her patients. As she passes the toaster again, she can pick up the perfectly toasted bread from the tray at the bottom. And while her toast is being made, other orders can be started. There's nothing to push or pull on a Savory. It's an automatic toaster that's *really* automatic. And cost of operation averages only  $\frac{1}{2}$ c to  $4\frac{1}{4}$ c for 180 to 720 slices of better toast an hour! Coupon brings complete details.



Have you seen the new Savory *radiant gas* Broiler—designed for hospital diet kitchens? Broils food vertically on both sides at the same time. Eliminates all unnecessary motions—saving *one-half to two-thirds* the time ordinarily required. Broils steaks, chops, hamburgers, chicken and fish. It costs only  $\frac{1}{2}$ c to  $2\frac{1}{4}$ c an hour to operate.

SAVORY, INC.  
Dept. M-H-7, 591 Ferry Street, Newark, N. J.  
Please send me, without obligation, complete information on the ☐ Savory *radiant gas* Toaster  
☐ Savory *radiant gas* Broiler  
NAME .....  
HOSPITAL .....  
ADDRESS .....



## NEWS OF THE MONTH (Cont'd)

### Fourteen Patients Enter Hospital Every Minute, Survey Shows

The care of the sick and injured in the United States requires 6,613 hospitals with a total capacity of 974,115 hospital beds, according to the eleventh annual presentation of hospital data by the Council on Medical Education and Hospitals, American Medical Association. This presentation is made in the *Journal of the American Medical Association* for June 11.

This number includes hospitals, sanatoriums and related institutions in the United States and 202 in the insular possessions. The names of 490 hospitals which, after investigation, were not accepted by the council, are omitted.

Hospitals are admitting patients at the rate of fourteen a minute, the investigation shows. For twenty-two years, hospitals have been built and equipped at the rate of one sixty-nine-bed hospital each day, including Sundays and holidays. Patients admitted in 1931 numbered 7,155,976. There were 708,889 babies born in hospitals last year, with the number of hospital births increasing at the rate of 50,000 a year. Physicians connected with hospitals now number 116,363, an increase of 25,460 over 1928.

The rate of occupancy in general hospitals for 1931 was found to be 64.4, as compared with 65.5 for 1929. These general hospitals, of which there are 4,309, have increased steadily in the number of beds. Their total bed capacity is 384,333, with 45,434 bassinets in addition. The general hospitals last year admitted 6,321,861 patients, about 88 per cent of all patients admitted to all hospitals during the year. There were also 641,823 births recorded in these hospitals, out of the total of 708,889 births in all hospitals.

Church hospitals, being supported in large part by donations, and the rest of their support coming mainly from patients, are among the hospitals that are most keenly feeling the depression, since many of their patients can no longer pay. Individual and partnership hospitals show a more rapid decline than any other group. Their capacity has shrunk from 39,118 five years ago to 36,764 at the present time. In the same time the average number of patients declined from 21,779 to 17,912. The independent hospital organizations, numbering 2,015, admitted 2,714,406 patients in 1931.

They have a capacity of 166,927, and their average daily census of patients is 107,350, which is only slightly below that of 1930.

Hospitals owned by governmental agencies—federal, state, city and county—number 1,816 with a total capacity of 641,524 beds and an average daily census of 569,301 patients. All hospitals other than the government owned had an average daily census of 206,095.

The federal government owns and operates 291 hospitals with a total capacity of 69,170 beds and 391 bassinets. Of these, fifty-five are hospitals of the Veterans' Administration having a capacity of 28,454 beds.

Other hospitals surveyed include industrial hospitals, hospitals for nervous and mental patients—which continue to increase—tuberculosis hospitals, maternity hospitals, convalescent and rest hospitals, isolation hospitals, children's hospitals and eye, ear, nose and throat hospitals.

### New Haven Hospital Completes Memorial Pavilion

The new Sarah Wey Tompkins Memorial Pavilion at the New Haven Hospital, New Haven, Conn., was recently opened for the care of patients. The pavilion is a six-story structure paralleling, and duplicating in size and appearance, the Raleigh Fitkin Memorial Pavilion with which it is connected by the clinic and service building at the center of the hospital grounds. The addition of the Tompkins Memorial completes a massive quadrangle of new, modern buildings.

The new pavilion contains 139 beds for surgical, obstetrical and emergency patients, and twenty-one bassinets. The first two floors, each with twenty-seven beds, are for men who are surgical and orthopedic patients. The third floor has twenty-seven beds for gynecologic patients, and the fourth floor twenty beds for obstetric patients and twenty-one bassinets for newborn infants. On the fifth floor are twenty-four beds for women who are general surgical patients.

Only three additional units are now needed for the completion of the New Haven Hospital, according to plans adopted a few years ago.

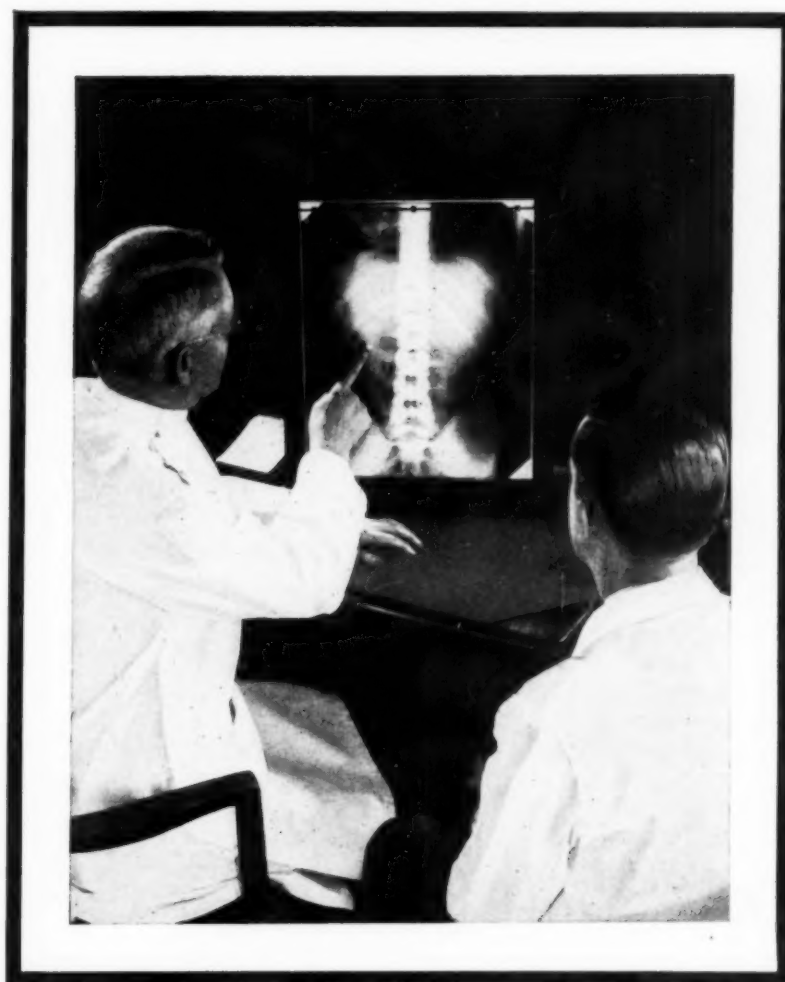
A picture of the new pavilion appears on the cover page of this issue.

PRO

If  
posit  
prom  
more  
When  
the r  
enhan  
Rad  
most  
ate, p  
ly, th  
findin

"Radio  
tograph  
devoted  
graphic  
your n

# GOOD RADIOGRAPHS PROVIDE



## PROTECTION FOR YOUR PATIENTS . . . PRESTIGE FOR YOUR HOSPITAL

If diagnosis is immediate and positive, treatment can be prompt and administered with more likelihood of success. When such conditions prevail, the reputation of the hospital is enhanced.

Radiography is perhaps the most valuable means to immediate, positive diagnosis. Frequently, the facts revealed in x-ray findings could not be obtained

in any other way. So, for the benefit of your staff, the protection of your patients, and the prestige of your institution, encourage extensive use of your x-ray service.

Such increased activity in the x-ray department need not materially affect the budget. For when Eastman Ultra-Speed or Eastman Diaphax X-ray Films are used, expenses are actually

curtailed. Their maximum sensitivity gives assurance of sharp detail even in soft tissue and parts that are difficult to immobilize . . . Thus fewer retakes are necessary, and wear and tear on expensive equipment is minimized. In addition, Eastman films are uniform so they facilitate standardization of methods, which saves time and conserves materials.

"Radiography and Clinical Photography" is a bimonthly magazine devoted to x-ray and clinical photographic work. The coupon will place your name on the mailing list.

EASTMAN KODAK COMPANY, Medical Division,  
343 State Street, Rochester, New York.

Please send me regularly the free publication, "Radiography and Clinical Photography," which I understand is devoted to x-ray and clinical photographic department problems.

Name ..... Institution .....

No. & St. .... City & State .....

## NEWS OF THE MONTH (Cont'd)

### A. H. A. Head Outlines Convention Plans in Letter to the Field

An invitation to all hospitals "to participate in the programs of the American Hospital Association at the annual meeting in Detroit, September 12 to 16, and to assist in the formulation of those policies that are best calculated to solve hospital problems in a satisfactory manner," has been sent out by Paul Fesler, president of the association.

"The hospital field benefits most and most rapidly when its component institutions, through their representatives, enter into a joint study and an open discussion of their problems," Mr. Fesler emphasizes. "In these conferences each hospital assists the others in working out sound plans of procedure that promise ultimate success. In no previous period in the history of hospitals have the advice and counsel of our institutions been so vitally necessary to the entire hospital field as they are in the present crisis."

#### *Detroit Program Takes Shape*

Topics that will receive full consideration on the Detroit program include: ways and means for increasing bed occupancy and hospital earnings; hospitals and their part in the program of the Committee on the Costs of Medical Care; hospitals and their part in the program on the White House Conference on Child Welfare; the use of civilian hospitals for the care of disabled veterans of our wars; hospitals and the education and training of nurses; hospital insurance for our communities and particularly for those members of the community in the lower brackets of wage earners; hospital legislation; workmen's compensation, lien, automobile and accident laws; ways and means for reducing the cost of hospital operation without the sacrifice of hospital efficiency; hospital economies in the purchase and use of supplies; hospital plans for financing capital indebtedness and its charges; hospital organization action to obtain payment for the care of indigent patients by the responsible political divisions—state, county, township and city; hospital participation in funds raised for unemployment and other relief.

Mr. Fesler concludes his letter with these significant words: "If our hospitals will work in close cooperation with each other and with the understanding of the policies and problems involved

there is no doubt but that our institutions will weather the existing conditions and will be able to discharge their full service to their communities. Your participation in the programs of the Detroit conference will be a valuable contribution not only to your own hospital and your own community, but to our institutions everywhere."

### New Jewish Hospital, Montreal, Is Almost Completed

The new Jewish Hospital, Montreal, the first of its kind ever built in Canada, is nearing completion, and it is expected that the formal opening will take place before next spring. The hospital is being built at a cost of a million and a quarter dollars. The nurses' home unit will be a future consideration.

The directors have already chosen Louis Cooper Levy, formerly of the Jewish Hospital, Cincinnati, to guide them in the purchase of equipment and also in planning for the administration of the new hospital.

The building was designed by J. Cecil McDougall, architect and engineer, with C. Davis Goodman as associate architect. Dr. S. S. Goldwater, New York City, was consultant.

### Legislative Matters Fill Program of South Dakota Association

Practically the whole of the South Dakota Hospital Association program this year was devoted to a discussion of legislative matters. The association met in Mitchell, S. D., June 7 and 8.

The only address given was on this topic and was made by Dr. H. J. Bartron, Watertown. Definite urgent hospital legislation was necessary, it was pointed out, and a committee will be appointed shortly to draw up bills for presentation to the state lawmakers this winter.

Sioux Falls was chosen as the convention city for 1933.

Officers chosen were: president, Dr. H. J. Bartron, Watertown; vice-president, Sister Mother Agatha, Sioux Falls; secretary-treasurer, C. W. Carlson, Sioux Falls; trustees, the Rev. J. S. Harkness, Mitchell, and Dagmar H. Einspahr, Redfield.





## OLIVE OIL—famed for beauty results

This much goes into every cake of Palmolive →

**D**ON'T think your patients don't know the difference between Palmolive and ordinary soaps! The overwhelming popularity of this soap proves millions know Palmolive is made with olive oil. The actual size, six-inch test tube at the right shows just how much olive oil goes into every cake.

Other soaps—they rarely even tell what they are made of. But Palmolive is proud of its ingredients—shows them to you. No wonder more than 20,000 beauty experts

both here and abroad urge the use of this one soap. Palmolive in your hospital shows patients you are considerate of their beauty needs.

In spite of its quality and prestige, Palmolive costs no more than ordinary soaps. Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. We will gladly send you prices of our five special sizes for hospitals. The coupon will also bring you our new free building cleanliness booklet. Mail it today!

### COLGATE-PALMOLIVE-PEET COMPANY

Palmolive Building, Chicago

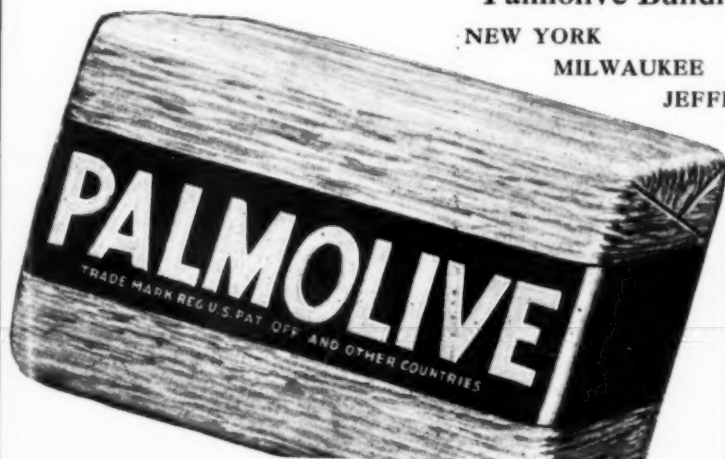
NEW YORK

KANSAS CITY

MILWAUKEE

SAN FRANCISCO

JEFFERSONVILLE, IND.



COLGATE-PALMOLIVE-PEET COMPANY  
Dept. MH-7, Palmolive Building, Chicago.

Without obligation send me your free booklet, *Building Cleanliness Maintenance*, together with Palmolive Soap prices.

Name.....  
(Please print name)  
Address.....  
City..... State.....

## NEWS OF THE MONTH (Cont'd)

### T. B. Kidner Dies—Pioneer in Work in Occupational Therapy

Thomas Bessell Kidner, a notable figure in the hospital field and founder of the American Occupational Therapy Association, died suddenly on June 14 at the home of his son in New York City.

Mr. Kidner, who was born in England sixty-six years ago and who came to the United States in



1915 by way of Canada, served for several years as institutional secretary, National Tuberculosis Association to which he was elected in 1919. He established an advisory service on the planning of institutions for tuberculous patients and aided in the development of curative occupations in sanatoriums. He resigned in 1926 to enter private practice as a consultant on the planning of all kinds of medical institutions. His most recent accomplishment was the completion of the first official directory and register of occupational therapists, which was recently published.

Mr. Kidner was trained in architecture and building construction at the Merchant Venturers College, Bristol, England, and completed his education in London. In 1900 he went to Canada as one of the

organizers under the fund for the improvement of technical education established by the late Sir William C. MacDonald of Montreal. In 1915 he was appointed vocational secretary of the Canadian Military Hospitals Commission when he helped develop the system of vocational rehabilitation of disabled Canadian war veterans. In 1918 he was lent to the United States to advise American authorities on vocational rehabilitation of the disabled.

He was a member of the editorial board of THE MODERN HOSPITAL and had been a long time contributor to THE MODERN HOSPITAL and to THE MODERN HOSPITAL YEAR BOOK.

### Hospital Field Day Attracts Crowds in Punxsutawney, Pa.

"An enormous crowd, a splendid exhibition and a beautiful day made June 14 a day long to be remembered in Punxsutawney, Pa. It was Hospital Field Day and Flag Day, an occasion that was celebrated by one of the finest shows ever given in this section of Pennsylvania." Such is the enthusiastic opening of a story in the *Punxsutawney Spirit*, which describes in detail the events of the day, beginning with a street parade and ending with a hospital ball.

Thousands of persons both from within and without the city watched the parade and later attended a delightful show at the Armory at a small admission price. The entertainment included races, exhibition riding, a drum corps drill by American Legion men, an exhibition of horsemanship given by the Gendarmes, a cavalry organization, a firefighting demonstration and an ambulance run and first-aid demonstration.

One of the outstanding features of the horse show was the jump made by the oldest active horse in the world—he is Woodrow, twenty-four years old—over a human hurdle. The horse also performed the difficult feat of jumping over two horses. In this event, he was ridden by Lieut. N. S. Scava, of the Gendarmes.

"To Col. L. C. Trimble, superintendent, Adrian Hospital, Punxsutawney, belongs the credit for the idea of the Hospital Field Day, and to every participant go the thanks of the hospital association and of the people of the community," the story concludes.

# Keleket X-ray Units Are Meeting the Supreme Test of Value

Naturally, time-tested Keleket X-ray units are chosen by the leading Roentgenologists. Science and engineering have designed them correctly and built them to meet those exacting demands that are vital to the successful operation of the X-ray laboratory.

Individuals and institutions alike are finding them the greatest value for every dollar invested.

Let a Keleket representative tell you of their advantages—or write for descriptive literature.



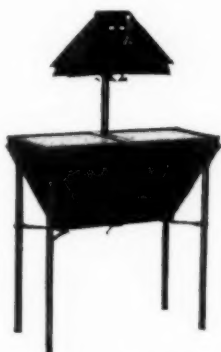
Keleket Angulating Head Tunnel  
with Granger Attachments.



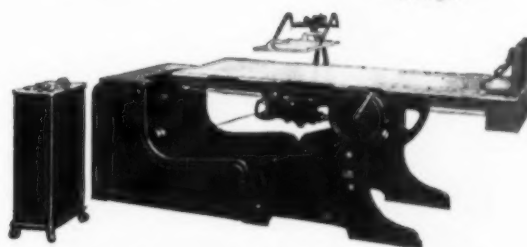
Keleket Vertical  
Fluoroscope.



Keleket Magnetic  
Pendulum Cassette  
Changer.



New Keleket Stanford  
Stereoscope.



Keleket JRK Model, Manually Operated Tilting Table.



Keleket 125,000 Peak Volt—1000 M. A. Stabilized,  
Full Wave, Tube Rectified X-ray Apparatus.



Keleket 300 K. V. Full Wave, Stabilized, Constant  
Potential, Condenser Filtered, Tube Rectified  
Therapy X-ray Apparatus.

## THE KELLEY-KOETT MFG. CO., Inc.

219 West Fourth Street

Covington, Kentucky

**Kelēket**  
X-RAY EQUIPMENT

AS MODERN AS TOMORROW



## NEWS OF THE MONTH (Cont'd)

### Michael Reese Provides Entire Floor for Chronic Patients

The newly completed first floor of Meyer House, Michael Reese Hospital, Chicago, is to be devoted to the care of patients suffering from chronic disorders. Meyer House is the hospital's private room pavilion.

The floor contains sixteen rooms, all of which have private toilet and lavatory facilities, and half have private baths in addition.

All the diagnostic and therapeutic facilities of the hospital, including its research laboratories and radium, are at the disposal of physicians caring for patients in this unit.

The cost for a private room with a private toilet and lavatory will be \$50 a week. These rates include general nursing care, all ordinary drugs and dressings, all special diets, all laboratory examinations—except x-ray and electrocardiographic—all occupational therapy and library service.

### Economic Adjustments Occupy Large Place on A. P. H. A. Program

A disquisition on the all important subject of "Balancing the Hospital Budget" is to be presented by the Protestant Hospital Association at its annual convention in Detroit, September 9 to 12, according to a recent announcement by Dr. Frank C. English, executive secretary of the association. Subjects, speakers and round tables will deal with the problems of practical economics in the handling of supplies, the administration of food, the prevention of waste and the conservation of resources.

The nursing committee will present a program on the standardization of nursing service. The speakers on this program will tell what the well trained nurse can and will do and will outline the service that is expected of her. One speaker will discuss training school standards.

In keeping with one of the objectives of the association, a helpful Sunday program has been arranged. The incoming president, Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J., will give the sermon. Other clergy of the association representing various church denominations will also take part in the service which will be held in the Detroit Episcopal Cathedral. In the afternoon an address on a balanced program for

making the Protestant hospitals Christian in character and efficient in service will be given and will be followed by a forum on the theme, "Humanizing the Hospital."

The convention opens at 2 o'clock Friday afternoon, September 9, and closes at noon the following Monday. Five round tables will occupy most of the time. A variety of subjects will be discussed, including legislation, administration, economics and public relations.

### Dean of Cook County School of Nursing Resigns

Laura R. Logan, dean, Cook County School of Nursing, Chicago, has submitted a letter of resignation to the school's board of directors which has been accepted. The resignation becomes effective November 1.

Miss Logan has served as the dean of the school for the last eight years. During the last few months her administration has been under fire during which charges of "undue extravagance in furnishing the new nurses' home," and "a failure to cooperate with the staff of the county hospital," were made.

In her letter Miss Logan said she was quitting in protest against a recent arbitration award reinstating forty-two striking male nurses at the psychopathic hospital. Their retention, she said, interfered with her plans for the reorganization of the nursing school.

Frank R. Shaw, chairman, board of directors, Cook County School of Nursing, also resigned, his resignation becoming effective July 1.

### Springfield Hospital Holds Dedictory Exercises

The Springfield Hospital, Springfield, Mass., held its dedicatory exercises on June 7. A special program was given in the morning for the visiting physicians. Henry A. Field, president, board of trustees, presided at the afternoon program, with the main addresses being made by Dwight Winter, mayor of Springfield, and Dr. F. A. Washburn, director, Massachusetts General Hospital, Boston. The history of the hospital was interestingly reviewed by Dr. Ralph H. Seelye.

# NEW The Famous Gorham Hot Water Plate

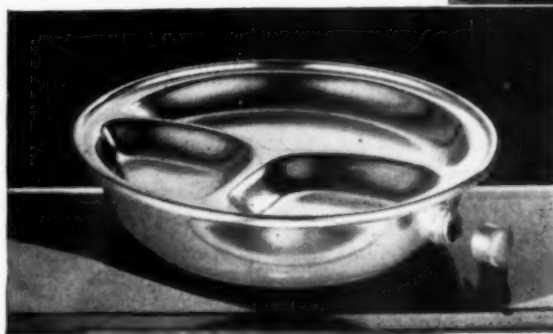
## with an EXTRA DEEP WELL



... and a new three-compartment Hot Water Plate



A GORHAM hot water plate is now being made with an extra deep well... And Gorham has added a three-compartment plate (also with deep well) to its line. These plates are easily filled and easily cared for. Following is a partial list of hospitals which use Gorham hot water plates:



ABOVE is the new hot water plate 8 1/2 inches in diameter. Cover to fit, 8 in. in diameter. LEFT is the inside view of the new three-compartment plate. (Size as above.)

No soft metal or soft solder is used in the construction of Gorham hospital silverware.

*Alameda, Calif.*  
Alameda Sanatorium  
*Berkeley, Calif.*  
Alta Bates Hospital  
*Buffalo, N. Y.*  
Children's Hospital  
*Clearfield, Pa.*  
Clearfield Hospital  
*Durham, N. C.*  
Watts Hospital  
*Haywood, Calif.*  
Haywood Central Hospital  
*La Jolla, Calif.*  
Scripps Metabolic Clinic

*Los Angeles, Calif.*  
Kaspar Cohn Hospital  
St. John's Hospital  
*Milwaukee, Ore.*  
Portland Open Air Sanatorium  
*Morristown, N. J.*  
All Souls Hospital  
*New York, N. Y.*  
French Hospital  
Hunts Point Hospital  
Neurological Institute  
*Oakland, Calif.*  
East Oakland Hospital  
Providence Hospital  
*Pasadena, Calif.*  
Pasadena Hospital

*Phoenix, Ariz.*  
St. Joseph's Hospital  
*Pittsburgh, Pa.*  
Allegheny General Hospital  
*Portland, Ore.*  
Dr. R. C. Coffee Clinic & Hospital  
St. Vincent's Hospital  
*Riverton, Wash.*  
Riverton Sanatorium  
*Sacramento, Calif.*  
Mater Misericordiae Hospital  
Sutter Hospital  
*San Francisco, Calif.*  
Children's Hospital  
Mount Zion Hospital  
St. Francis Hospital

*San Francisco, Calif. (continued)*  
St. Joseph's Hospital  
St. Luke's Hospital  
*San Luis Obispo, Calif.*  
San Luis Obispo County General Hospital  
*San Mateo, Calif.*  
Mills Memorial Hospital  
*Santa Barbara, Calif.*  
Santa Barbara Cottage Hospital  
*Seattle, Wash.*  
Swedish Hospital  
*Stamford, Conn.*  
Stamford Hospital  
*Woodland, Calif.*  
Woodland Clinic

Write for new catalogue just issued

# THE GORHAM COMPANY

HOSPITAL AND HOTEL DIVISION

NEW YORK—6 West 48th Street  
CHICAGO—10 S. Wabash Avenue  
SAN FRANCISCO—972 Mission Street

**GORHAM HOSPITAL SILVERWARE IS MADE UP TO A STANDARD NOT DOWN TO A PRICE**  
Memorial Tablets and Endowment Plates in Brass and Bronze, write our Bronze Department Q for suggestions and estimates.

## PERSONALS

DR. CHARLES CRANE, formerly resident superintendent, Carson C. Peck Memorial Hospital, Brooklyn, N. Y., died May 28 after an illness of several months. Prior to his illness, DOCTOR CRANE had been doing consultation work for many years.

E. M. COLLIER, superintendent, West Texas Baptist Sanitarium, Abilene, Tex., was recently elected president, Northwest Texas Clinic and Hospital Managers Association.

DR. S. R. D. HEWITT is now serving as superintendent, St. John General Hospital, St. John, N. B. Doctor Hewitt was formerly superintendent, Regina General Hospital, Regina, Sask. DR. H. H. MITCHELL succeeds DOCTOR HEWITT as superintendent at Regina.

JESSIE CHRISTIE, for the last eighteen years superintendent, Chicago Lying-in Hospital, Chicago, has resigned. Her resignation becomes effective September 1. MISS CHRISTIE will take a needed rest in Florida.

CHARLOTTE HOWELL was recently named superintendent, Valley Hospital, Downey, Calif.

LILLIAN FRASER is the newly appointed superintendent, Eliot Private Hospital, Boston.

L. B. MCWILLIAMS is now serving as superintendent, Holdenville Hospital, Inc., Holdenville, Okla.

MRS. H. M. MARKWELL was recently appointed superintendent, Dr. Jervey's Hospital, Greenville, S. C.

JEAN LONGBRIDGE is now superintendent, Bivings & Barcus Hospital, Big Spring, Tex.

E. HEATH, R.N., is the newly appointed superintendent, Northampton Accomac Memorial Hospital, Nassawadox, Va.

W. W. RAWSON, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah, was married recently to Erma Madsen, superintendent of nurses at the hospital.

DR. JAMES EWING, for thirty years professor of pathology, Cornell University Medical College, New York City, has been appointed director, Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City.

SISTER HERMINE was recently named superintendent, Providence Hospital, Montreal.

HAZEL ALKINE MILLARD, superintendent, Freeman City Hospital, Linton, Ind., is the newly appointed superintendent, Mary Sherman Memorial Hospital, Sullivan, Ind., succeeding L. GERTRUDE DEVINE, resigned.

ALICE M. GAGGS has resigned as superintendent, Norton Memorial Infirmary, Louisville, Ky. MARY L. HICKS, executive secretary, Louisville Health Council, Community Chest, is serving now as acting superintendent.

ANNIE HATHEWAY SMITH, who served for two years as superintendent, Rockville City Hospital, Rockville, Conn., prior to January, 1929, when she left to go to the home of her mother who was then seriously ill, has been again appointed superintendent of the hospital. She succeeds WINNIFRED H. BROOKS, resigned.

FRANCIS VAN BUREN has been appointed superintendent, Children's Hospital, Cincinnati, succeeding ELIZABETH PIERCE who resigned in March after ten years of service. MR. VAN BUREN will also have charge of the administration of the new Children's Hospital Research Foundation. He has spent the last few months making a study of hospital administration methods in leading hospitals of the United States and Canada.

MRS. ALTON KEATHLEY, formerly dietitian, Cleveland Clinic Hospital, Cleveland, has been appointed dietitian, Methodist Hospital, Memphis, Tenn.

DR. E. H. MAGGARD was recently appointed superintendent, Eastern State Hospital, Lexington, Ky. He succeeds DR. F. G. LARUE, superintendent since 1921, who resigned because of ill health.

LIEUT.-COL. WALTER L. SIMPSON, for two years superintendent, Grace Hospital, New Haven, Conn., has resigned, his resignation to become effective August 1. HARRY V. WHIPPLE, former city treasurer, will serve as acting superintendent.

DR. W. A. QUINN has been named by the board of charities and corrections for Kentucky to succeed DR. J. E. FOX as superintendent, Central State Hospital, Lakeland, Ky.

LEONE MACNAMARA recently became superintendent, Clay Center Municipal Hospital, Clay Center, Kan. She succeeds BERTHA PACE who becomes superintendent of nurses, Park View Hospital, Manhattan, Kan., on August 1.



# *New findings show this the most digestible form of cow's milk*

*Children's clinics, leading  
physicians discover many  
advantages in feeding  
evaporated milk*



**I**T'S the experience of many leading children's clinics and practitioners that babies fed on evaporated milk are better fed than those whose formula is based on other forms of cow's milk.

Not only better fed, but they are freed from many digestive upsets that foods may cause.

Libby's Evaporated Milk is milk in its most digestible form . . . which, in the stomach, makes a soft curd like mother's milk . . . whose protein is more readily split by the digestive enzymes than that of either raw or pasteurized milk.

In any feeding formulas—for normal babies or for the sick, undernourished or premature—you can use Libby's Milk and get better results.

And mothers will find it is less expensive than any other form of cow's milk—even when formulas require a larger than usual proportion of milk.

Over half the water has been removed. So, simply by mixing Libby's Milk and water in equal amounts, you get the volume equivalent of bottled milk, somewhat richer than average quality.

Libby's Evaporated Milk is pure cow's milk only, from selected herds . . . "reductase tested" at the condensaries daily with methylene blue to assure utmost cleanliness . . . autoclaved at 240-242°F., preventing any bacterial contamination . . . homogenized to disperse the fat evenly.

Then, too, it carries the official Seal of Acceptance of the American Medical Association.

This explains why so many pediatricians are prescribing Libby's Evaporated Milk regularly.

Write us for free booklets containing authoritative discussions of the use of evaporated milk in infant feeding. Simply address . . .

**Libby, McNeill & Libby**  
Dept. N-37, Welfare Bldg., Chicago

## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

# Recent Progress in Nutrition and How It Affects the Dietitian

By SYBIL L. SMITH

Office of the Experiment Stations, United States Department of Agriculture

SINCE the foundations of successful nutrition in the child are laid before birth, it seems logical in this review of recent literature on the subject to start with nutrition in pregnancy and follow it through the life cycle to maturity, giving the remaining space to a few recent developments in clinical research in which the dietitian has played a prominent part.

### *Nutrition During the Reproductive Cycle*

In an editorial in the *Journal of the American Medical Association*<sup>1</sup> the statement was made that "pregnancy has been defined as essentially a problem in nutrition at a time when the dominant metabolic forces are such as favor growth." Whether or not these growth requirements are met can be determined to some extent by metabolism experiments throughout pregnancy.

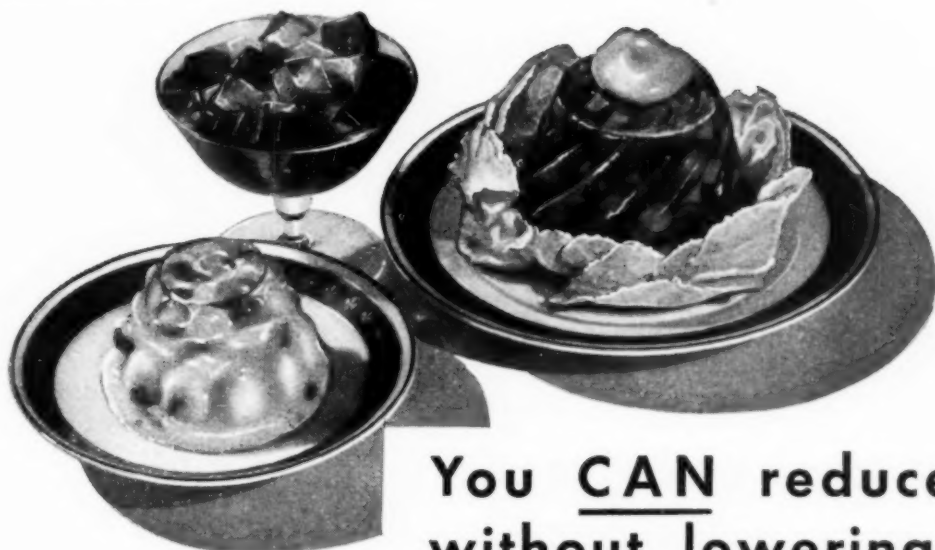
From basal metabolism studies on the same subject before, during and following two pregnancies, Sandiford, Wheeler and Boothby<sup>2</sup> concluded that the gradual increase in total heat production during pregnancy can be accounted for by the added metabolism of the fetus, placenta and accessory structures. In this subject after the nineteenth week of pregnancy, on an adequate nitrogen intake there was a gradually increasing positive nitrogen balance varying between 0.5 and 1.1 grams daily.

Macy and her co-workers<sup>3</sup> reported positive nitrogen, calcium and phosphorus balances in a healthy subject on a carefully selected diet during the seventh and eighth months of a first pregnancy. They stated that "it is only through the accumulation of such case histories that the fundamental knowledge of maternal well-being upon which

sound advice can be based and disseminated can be acquired." A further proof of the adequacy of the selected diet for the needs of pregnancy was that the subject was able to continue her usual physical and mental activities throughout pregnancy and to produce milk of sufficient quantity and good enough quality to promote satisfactory growth and development of the infant.

The two cases cited represent, in one instance, successive pregnancies with a considerable interval of time between the two and, in the other instance, the first pregnancy. What is the situation in frequently repeated pregnancies? The extensive series of studies by Macy and her co-workers on subjects who were superior milk producers of the Mother's Milk Bureau of Detroit provide a wealth of information on nutrition throughout successive reproductive cycles of women who were ideal milk producers from the standpoint of both quality and quantity.

The first of these studies<sup>4</sup> conducted on three subjects showed that in the latter half of a pregnancy following a prolonged period of heavy milk production the nitrogen balances continued to be positive for the most part, but that in spite of large intakes of calcium and phosphorus the calcium balances were frequently negative and the phosphorus balances occasionally so. As brought out in the next paper<sup>5</sup>, the calcium losses were even greater during lactation than in pregnancy, and greater in the second of two successive lactation periods than in the first, in spite of increased consumption of food. There was also a greater tendency to negative phosphorus balances in the second of the two lactation periods. Supplementing the



You CAN reduce food costs  
without lowering quality—for

## JELL-O NOW COSTS LESS

In figuring how to reduce your food costs without lowering quality, here's good news:

## JELL-O NOW COSTS LESS

Here's a product that will help you balance your budget as well as balance your menus. And it's now at the lowest price you ever paid for "America's Most Famous Dessert."

But of course Jell-O is today more than a dessert. One of the reasons for its present peak of popularity is the fact that so many new ways of serving Jell-O have been developed. Today, this delicious, economical food is now used in a great variety of salads and entrées, as well as unusual desserts.

Although Jell-O always did have a very low food cost, it is now even less than *one cent* a portion, because:

## JELL-O NOW COSTS LESS

Think over that food cost. Think of all the ways to use Jell-O. Or better, send for a free assortment of tested quantity recipes for new and unusual Jell-O dishes. Let your chef try them out. Let him figure the exceptionally low food costs in comparison with other salads and desserts. And finally, remind your chef and yourself that:

## JELL-O NOW COSTS LESS

There is only one

# JELL-O

REG. U. S. PAT. OFF.

A PRODUCT OF GENERAL FOODS CORPORATION

Check the types of recipes you want:

☐ SALADS   ☐ ENTRÉES   ☐ DESSERTS

Pin this coupon to your business letterhead. Write your name and position on it. Mail to Institution Department, General Foods Sales Co., Inc., 250 Park Ave., N. Y. C.

M. H.-7-32



diet for a short time with yeast and cod liver oil<sup>6</sup> checked somewhat the losses in both calcium and phosphorus.

At the close of the second lactation period<sup>7</sup> the three subjects showed a negative calcium and a positive phosphorus balance. During the subsequent period of reproductive rest calcium losses and phosphorus storage continued, leading the authors to comment: "From these results it seems that the maternal organism requires many months to readjust itself after closely repeated pregnancies, and long, intense lactation. Such findings demonstrate a real need for some means of accelerating the return of calcium metabolism to a plane of equilibrium or storage in mothers who have suffered a depletion during the reproductive cycle."

#### *Mineral Retention During Pregnancy*

It might be assumed that such upsets in calcium metabolism as these studies have shown would affect the chemical make-up of the bones of the newborn infant. This is implied in the study made by Coons and Blunt<sup>8</sup> on mineral metabolism during pregnancy, in which comparisons were made of the average daily calcium retention at definite intervals with the daily fetal demand for calcium as calculated from published fetal analyses. Recent analyses by Booher and Hansmann of the tibias of newborn infants secured postmortem<sup>9</sup> have shown, however, a striking constancy in the percentage of calcium in the ash regardless of the previous nutritional histories of the mothers, some of whom had had several previous pregnancies and others of whom were so young that active calcification of their own bones should have been taking place simultaneously.

Quantitative records of the food consumption<sup>10</sup> as well as of the sources of nutrients in terms of principal groups of foodstuffs<sup>11</sup> during the entire reproductive cycle of the three subjects of the metabolism studies of Macy showed greatly increased food consumption during lactation as compared with the pregnancy and postlactation periods, but no significant changes in food selection beyond a larger proportion of milk during lactation. The percentage distribution of calories among the various food groups corresponded favorably on the whole with the distribution suggested by Rose for adults on a moderate income. The efficiency of these women in milk production was calculated by comparing their intake of calories, protein, fat, carbohydrate, calcium and phosphorus with the content of these food essentials in the daily output of milk during the long lactation period studied.<sup>12</sup> In calculating the total energy requirement of these women, the allowances for the actual process of milk secretion

suggested by Rose, of 10 per cent of the calory output in the milk, and by Rand, Sweeny and Vincent, of two food calories for each calory secreted in the milk, were both used.

It is interesting to find that in these superior milk producers there would have been left for maintenance on the former allowance 2,000, 3,000 and 2,600 calories and on the latter more liberal allowance for the needs of milk production, 100, 1,600 and 1,600 calories for the three subjects, respectively. The fact that only small losses in weight were shown by the first two subjects and a slight gain by the third indicates that the second of the two allowances would have been far too liberal.

Similar calculations of the quantities of the various food essentials available for utilization in metabolism showed them to be fully adequate even in the case of calcium and phosphorus, although as has been noted the calcium balances were negative throughout most of the lactation period and the phosphorus balances occasionally negative. Commenting upon the inability of these women to utilize the apparently available calcium, the authors state, "It is evident that providing an adequate diet is not the only essential. More satisfactory ways and means of inducing better digestion, absorption and assimilation of the food materials into the body must be devised if lactation is to leave the maternal body unimpaired."

#### *Infant Feeding*

Several questions concerning the composition of breast milk have been answered by Macy and her associates. Analyses<sup>13</sup> of the milk produced by the subjects of the metabolism experiments during the first and last halves of the nursing period showed that as nursing progresses the milk becomes much richer in fat, protein, casein-nitrogen, total solids and phosphorus. These findings are of practical significance. A small weak baby unable to nurse for more than a few minutes might benefit by having the first portion of milk removed before it was allowed to nurse. At the other extreme the fact that eczema, which sometimes develops in vigorous, breast fed babies, has been cured by shortening the nursing period, thus permitting the baby to get only the first and more dilute portion of the milk, suggests that the skin condition has been caused by the richness of the milk, probably in fat.

No appreciable differences<sup>14</sup> were found in the composition of the entire volume of milk from each breast emptied within a fifteen-minute period, but marked differences were found in the total daily output.

The concentration of vitamin B (complex) in

# HERE'S A CORRECTIVE FOOD ... *that keeps its secret to itself!*



MANY corrective foods, excellent in their own right, unfortunately have a "corrective flavor" that sends them back to the kitchen untouched. But Heinz Rice Flakes are so full of good flavor that patients never think of them as a corrective food.

Yet they are. These crisp, crunchy flakes have an important laxative quality—a quality that has been demonstrated in a series of carefully supervised institutional tests.

Heinz Rice Flakes have this helpful laxative action because pure *corrective cellulose*, made

from the whole rice grain, is combined with them. This corrective cellulose absorbs moisture after eating and forms one of the gentlest, mildest types of bulk. Its action can best be compared to that of the cellulose in certain fruits and vegetables.

It took four years for the H. J. Heinz Company, in collaboration with the Mellon Institute, to perfect the special process that gives Heinz Rice Flakes their added correc-

tive cellulose content. No other rice cereals contain this valuable element.

We believe you will find Heinz Rice Flakes a pleasant and helpful addition to your menus. Our representative has further interesting information about Heinz Rice Flakes, and will be glad to call upon you. At the same time, he'll arrange for a generous free trial. For convenience, mail us the coupon below.

## HEINZ RICE FLAKES •

H. J. HEINZ COMPANY,  
Dept. MH7, Pittsburgh, Pa.

Please have your salesman call, regarding Heinz Rice Flakes.

Name .....

Street .....

City..... State.....

THE ONLY READY-TO-SERVE CEREAL THAT  
CONTAINS ADDED CORRECTIVE CELLULOSE

"ONE OF THE  
**57**  
VARIETIES"

the milk was found to vary inversely with the total volume of the milk,<sup>15</sup> suggesting the possibility of a "greater demand for vitamin B in the actual protoplasmic processes involved in the elaboration of large quantities of milk." Supplementing the diet of the women with 10 grams of yeast daily increased somewhat the vitamin B content of the milk, but was apparently more effective in introducing something into the milk that promoted better growth on the same caloric intake.

#### *Enriching Breast Milk and Cow's Milk*

Fresh pooled breast milk from the Mother's Milk Bureau of Detroit was found by Donelson and Macy<sup>16</sup> to be comparatively low in its content of vitamin G, although the women producing the milk were receiving presumably adequate diets. It seems that the practice of giving artificially fed babies supplements of vitamin B (B and G) might well be extended to breast fed babies. In Hoobler's experience<sup>17</sup> brewer's yeast concentrate or powdered yeast is a more effective means of supplying the vitamin B complex to babies than the extract of wheat germ more commonly used.

Much attention has been paid in recent years to the quality of cow's milk used for infant feeding and to the possibility of enriching it in certain constituents by suitable feeding of dairy cattle. The discovery by Hill,<sup>18</sup> that the curd of the milk produced varies greatly according to the breed and the individual cows and that for infant feeding soft curd milk is greatly to be preferred, has been taken up by milk distributing organizations and soft curd milk is already available in several cities throughout the country. Chemical<sup>19</sup> and physiologic<sup>20</sup> studies of soft curd milk point to its value from the standpoint of ease of digestibility.

Earlier studies by MacLeod of the vitamin C content of raw milk from a single dairy of cows stall fed throughout the year on a ration consisting of alfalfa hay of excellent quality, a good silage and a concentrate have been extended<sup>21</sup> to vitamins A, B (B<sub>1</sub>) and G (B<sub>2</sub>), with the conclusion that the milk from cows thus fed is a good source of all these vitamins. In Sherman units the milk contained per gram from 1.3 to 2 units of vitamin A, about 0.1 unit of vitamin B and about 0.3 unit of vitamin G. Gunderson and Steenbock,<sup>22</sup> however, do not consider either cow's milk or goat's milk to be a good source of vitamin B, regardless of the breed of the animals or how they are fed, and state emphatically, "Our findings that cow's milk and goat's milk cannot have their vitamin B content increased beyond the usual level emphasize the necessity for recognizing the definite limitation of cow's and goat's milk in normal human nutrition."

The feasibility of enriching cow's milk with

vitamin D by feeding the cows irradiated yeast was demonstrated by Thomas and MacLeod<sup>23</sup> and received clinical support from Hess and his associates,<sup>24</sup> who reported the prevention and cure of rickets in a large number of babies from one and a half to six months of age receiving the antirachitic vitamin from no other source than milk from cows which had been fed irradiated dried brewer's yeast. Hess is of the opinion that this method of supplying vitamin D to babies is promising from a clinical point of view in that it functions automatically in the diet, relieving the physician of dependence on the cooperation of the mother. At present this vitamin D milk, which is said to be from twenty to thirty times as rich in vitamin D as ordinary milk, is on the market as certified vitamin milk in several Eastern cities. Might not the regular use of such milk during lactation help to prevent the waste of calcium noted in the studies of Macy and her associates?

If it is possible to secure a soft curd milk rich in vitamins A and D and a good source of G, with the deficiencies in vitamins B and C compensated by supplements of yeast or wheat germ extracts for B and orange or tomato juice for C, are all of the problems of the artificial feeding of infants solved? Apparently not. Among the problems still receiving attention, particularly in connection with the greatly increased use of concentrated preparations of milk such as evaporated and dried milks, is that of mineral retention on cow's milk as compared with breast milk. Long continued metabolism studies on infants receiving undiluted cow's milk, beginning at two weeks of age with the customary supplements at later periods, have been reported by Nelson, with the conclusion that feedings of undiluted milk are well tolerated and produce an increased rate of growth,<sup>25</sup> with favorable retentions of calcium and phosphorus.<sup>26</sup>

#### *Comparison of Cow's Milk and Breast Milk*

A comparison by Swanson<sup>27</sup> of the growth and retention of nitrogen and minerals of two normal infants during a period of over 100 days, one receiving breast milk and one cow's milk (reconstituted powdered whole milk), showed greater gains in weight and a considerably higher retention of nitrogen, calcium and phosphorus in the infant fed cow's milk than in the one fed breast milk. Commenting upon these findings, the author states, "The data presented indicate that supermineralization takes place in an infant on a food higher in concentration of salt than that intended by nature. No definite evidence is available to show that this is detrimental to the infant. The idea, however, may suggest itself that the disturbances attributed to continued feeding of whole



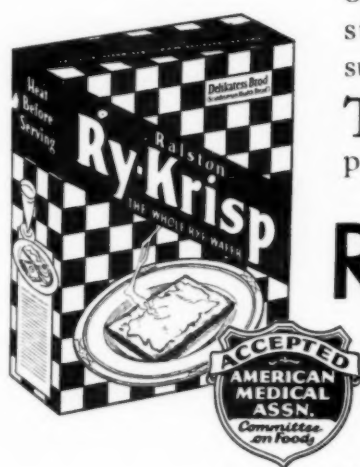
# If YOU were on a wheat-free diet you'd prefer *these* delicious wafers

**I**F YOU were placed upon a wheat-free diet—you'd welcome a bread which tastes perfectly delicious, yet is absolutely safe to eat.

**R**emember, when you are planning diets for patients sensitive to wheat, that Ry-Krisp wafers may be included at any time, with perfect safety. They are simply whole flaked rye (no other grain ever enters our plant), water and a dash of salt—double-baked into thin wafers of inviting crispness.

**Y**ou're assured of uniform excellence in Ry-Krisp wafers, too—because every step in the process of their manufacture, from the cleaning of the rye to the final packing, is subject to the strictest scrutiny and competent laboratory supervision.

**T**ry this delicious wheat-free bread at our expense. A sample will be sent to you free of charge.



## Ry-Krisp *Whole Rye Wafer*

RESEARCH DEPT., RALSTON PURINA COMPANY, ST. LOUIS, MO.  
Without obligation, please send me your complete Research Report on Ry-Krisp and a supply for testing.

Name.....

Address.....

City.....

HOSPITAL 7-32

This offer limited to residents of the United States and Canada.

cow's milk may be due in part to this increased mineral retention."

Individual differences in food utilization in such comparisons of breast milk and cow's milk were ruled out by Witt<sup>25</sup> through feeding the same infants alternately on breast milk and cow's milk, with the conclusion that the absolute retentions of calcium and phosphorus were greater on cow's milk than on breast milk, but that the percentage utilization was higher on the breast milk.

#### References

- <sup>1</sup>Editorial, Nutrition and Pregnancy, Jour. Am. Med. Ass'n, vol. 98, 1932, pp. 1088, 1089.
- <sup>2</sup>Sandiford, L., Wheeler, T., and Boothby, W. M., Metabolic Studies During Pregnancy and Menstruation, Am. Jour. Physiol., vol. 96, 1931, pp. 191-202.
- <sup>3</sup>Macy, I. G., Donelson, E., Long, M. L., Graham, A., Sweeny, M. E., and Shaw, M. M., Nitrogen, Calcium, and Phosphorus Balances in Late Gestation Under a Specified Dietary Régime, Jour. Am. Dietetic Ass'n, vol. 6, 1931, pp. 314-320.
- <sup>4</sup>Macy, I. G., Hunscher, H. A., Nims, B., and McCosh, S. S., Metabolism of Women During the Reproductive Cycle: I, Calcium and Phosphorus Utilization in Pregnancy, Jour. Biol. Chem., vol. 86, 1930, pp. 17-35.
- <sup>5</sup>Hunscher, H. A., Metabolism of Women During the Reproductive Cycle: II, Calcium and Phosphorus Utilization in Two Successive Lactation Periods, Jour. Biol. Chem., vol. 86, 1930, pp. 37-57.
- <sup>6</sup>Macy, I. G., Hunscher, H. A., McCosh, S. S., and Nims, B., Metabolism of Women During the Reproductive Cycle: III, Calcium, Phosphorus and Nitrogen Utilization in Lactation Before and After Supplementing the Usual Home Diets with Cod Liver Oil and Yeast, Jour. Biol. Chem., vol. 86, 1930, pp. 59-74.
- <sup>7</sup>Donelson, E., Nims, B., Hunscher, H. A., and Macy, I. G., Metabolism of Women During the Reproductive Cycle: IV, Calcium and Phosphorus Utilization in Late Lactation and During Subsequent Reproductive Rest, Jour. Biol. Chem., vol. 91, 1931, pp. 675-686.
- <sup>8</sup>Coons, C. M., and Blunt, K., The Retention of Nitrogen, Calcium, Phosphorus and Magnesium by Pregnant Women, Jour. Biol. Chem., vol. 86, 1930, pp. 1-16.
- <sup>9</sup>Booher, L. E., and Hansmann, G. H., Studies on the Chemical Composition of the Human Skeleton: I, Calcification of the Tibia of the Normal Newborn Infant, Jour. Biol. Chem., vol. 94, 1931, pp. 195-205.
- <sup>10</sup>Shukers, C. F., Macy, I. G., Donelson, E., Nims, B., and Hunscher, H. A., Food Intake in Pregnancy, Lactation, and Reproductive Rest in the Human Mother Jour. Nutrition, vol. 4, 1931, pp. 399-410.
- <sup>11</sup>Shukers, C. F., Macy, I. G., Donelson, E., Nims, B., and Hunscher, H. A., Sources of Nutrients Chosen by Women During Pregnancy, Lactation and Reproductive Rest, Jour. Am. Dietetic Ass'n, vol. 7, 1931, pp. 235-251.
- <sup>12</sup>Shukers, C. F., Macy, I. G., Nims, B., Donelson, E., and Hunscher, H. A., A Quantitative Study of the Dietary of the Human Mother with Respect to the Nutrients Secreted into Breast Milk, Jour. Nutrition, vol. 5, 1932, pp. 127-139.
- <sup>13</sup>Macy, I. G., Nims, B., Brown, M., and Hunscher, H. A., Human Milk Studies: VII, Chemical Analysis of Milk Representative of the Entire First and Last Halves of the Nursing Period, Am. Jour. Dis. Child., vol. 42, 1931, pp. 569-589.
- <sup>14</sup>Brown, M., Macy, I. G., Nims, B., and Hunscher, H. A., Human Milk Studies: VIII, A Comparison of the Composition of the Milk from the Two Breasts, Am. Jour. Dis. Child., vol. 43, 1932, pp. 40-51.
- <sup>15</sup>McCosh, S. S., Macy, I. G., and Hunscher, H. A., Human Milk Studies: VI, Vitamin Potency as Influenced by Supplementing the Maternal Diet with Yeast, Jour. Biol. Chem., vol. 90, 1931, pp. 1-13.
- <sup>16</sup>Donelson, E., and Macy, I. G., Human Milk Studies: XI, Vitamin G (B<sub>2</sub>) Content of Mixed Milk, Am. Jour. Physiol., vol. 100, 1932, pp. 420-425.
- <sup>17</sup>Hoobler, B. R., Use of Vitamin B in Diets of Infants, Jour. Am. Med. Ass'n, vol. 96, 1931, pp. 675-677.
- <sup>18</sup>Hill, R. L., Soft Curd Milk: Nature's Food for Infants, Arch. Pediat., vol. 48, 1931, pp. 417-425.
- <sup>19</sup>Weisberg, S. M., Soft Curd Milk, West. Hosp. Rev., vol. 18, 1932, pp. 28, 29.
- <sup>20</sup>Espe, D. L., and Dye, J. A., Effect of Curd Tension on the Digestibility of Milk, Am. Jour. Dis. Child., vol. 43, 1932, pp. 62-69.
- <sup>21</sup>MacLeod, F. L., Brodie, J. B., and Maclooin, E. R., The Vitamin A, B (B<sub>1</sub>), and G (B<sub>2</sub>) Contents of Milk Throughout the Year, Jour. Dairy Sci., vol. 15, 1932, pp. 14-22.
- <sup>22</sup>Gunderson, F. L., and Steenbock, H., Is the Vitamin B Content of Milk Under Physiological Control? Jour. Nutrition, vol. 5, 1932, pp. 199-212.
- <sup>23</sup>Thomas, B. H., and MacLeod, F. L., Increasing the Vitamin D Potency of Cow's Milk by Daily Feeding of Irradiated Yeast or Irradiated Ergosterol, Science, vol. 73, 1931, pp. 618-620.
- <sup>24</sup>Hess, A. F., Lewis, J. M., MacLeod, F. L., and Thomas, B. H., Antirachitic Potency of the Milk of Cows Fed Irradiated Yeast or Ergosterol: A Clinical Test, Jour. Am. Med. Ass'n, vol. 97, 1931, pp. 370-374.
- <sup>25</sup>Nelson, M. VanK., The Growth and Nitrogen Metabolism of Infants Receiving Undiluted Milk, Am. Jour. Dis. Child., vol. 39, 1930, pp. 701-710.
- <sup>26</sup>Nelson, M. VanK., Calcium and Phosphorus Metabolism of Infants Receiving Undiluted Milk, Am. Jour. Dis. Child., vol. 42, 1931, pp. 1090-1099.
- <sup>27</sup>Swanson, W. W., The Composition of Growth: II, The Full-Term Infant, Am. Jour. Dis. Child., vol. 43, 1932, pp. 10-18.
- <sup>28</sup>Witt, D. B., Phosphorus Metabolism in Infants: A Comparative Study of the Phosphorus Metabolism of Healthy Infants Fed Breast Milk and Cow's Milk, Am. Jour. Dis. Child., vol. 43, 1932, pp. 306-316.

(To be continued)

## What We Need to Know About Food

FOODS IN HEALTH AND DISEASE, by Lulu G. Graves, consultant in nutrition and diet therapy, The Macmillan Company, New York City.

A book on foods coming from the pen of Miss Graves cannot fail to command the instant attention of the ever widening circle of those interested in nutrition and diet therapy. The author's outstanding position in the field, her varied experience as a consultant in everything that relates to diet, the honor accorded her by the American Dietetic Association in making her its honorary president, lend a weight to her words that should ensure her a large and interested group of readers.

"Foods in Health and Disease" is designed to appeal to the unprofessional reader as well as to the doctor, the dietitian, the nurse and the home economics worker. The text covers, as stated in the preface, the practical points regarding food materials, their production and transportation; their care in the home and in the market; the dietetic value of the well known foods and of some others not so well known.

The book is in two sections. Section 1, which occupies about three-quarters of the space, is devoted to foods in health, under the following chapter headings: food elements; function of food and factors which influence nutrition; vegetables; fruits; sugars; nuts; animal foods; fats and oils; beverages; food accessories; preservation of foods.

Section 2 deals with foods in disease and includes chapters on therapeutic diets; overweight and underweight; infectious diseases; nephritis—gout and arthritis—epilepsy; gastro-intestinal diseases; diabetes; deficiency diseases; diseases of the circulation; infant feeding and food allergies.

A particularly commendable and helpful feature of this book is the bibliography at the end of each chapter. An appendix gives three valuable tables—a table of household measurements, a table of vitamins and a table of edible organic nutrients.

## Traveling Dental Clinic Serves Isolated Ontario Districts

A railway coach, reconditioned as a traveling clinic, was put into service in the Province of Ontario a few months ago, under an agreement between the department of public health of the province and the Canadian Pacific Railway Co.

The dental clinic serves the same small villages and isolated districts that are reached by five traveling school cars that are providing an education for children that otherwise might have none.

---

## Cases in which caffeine is contraindicated

---

THE effects of the drug caffeine on the heart, the nervous system, and the stomach are well established. These effects vary not only according to the person, but also at different times with the same individual.

Thus a patient who ordinarily tolerates caffeine, can suddenly become very sensitive to the drug. The condition frequently occurs in pregnant women, in digestive disorders, in anemia, and in all neurotic conditions. Also, with advancing years, the effects of the drug are noticeably more pronounced.

The value of a coffee that is free of caffeine effect *in all these cases* is apparent. Rather than ban coffee from the diet, it is often better to suggest a change

of blend from a coffee with caffeine to Kellogg's Kaffee Hag Coffee. In this way, all the benefits of a warm drink are retained and there is no restriction placed upon the patient's taste.

Kellogg's Kaffee Hag Coffee is simply a fine blend of coffee from which 97% of the caffeine and all the indigestible wax have been removed. Experts praise the flavor of this new, improved coffee. They say it is unsurpassed for flavor, aroma, and cup qualities by any other fine coffee.

The Kellogg Company will be pleased to send you a professional sample of this fine coffee. A request addressed to the Kellogg Company, Battle Creek, Michigan, will be given immediate attention.

---



# HOSPITAL EQUIPMENT AND OPERATION

Conducted by C. W. MUNGER, M.D.  
Director, Grasslands Hospital, Valhalla, N. Y.

## An Electrolytic Cell for Making Dakin's Solution

By WILLIAM H. ZABEL  
Pharmacist, St. Luke's Hospital, Chicago

THE immense value of the Carrel technique for the treatment of infected wounds by means of Dakin's hypochlorite solution was established during the World War, and prevented the incapacity or death of large numbers of wounded men. The sterilizing of infected and suppurating wounds with Dakin's solution is not successful unless the solution meets the defined standard.<sup>1</sup> There are many surgeons who do not follow the Carrel technique simply because of the difficulty in obtaining fresh, neutral hypochlorite solution of the correct concentration.

St. Luke's Hospital, Chicago, uses large quantities of Dakin's solution for the suppression of wound infection, and has considered the various processes for producing the solution. It has also investigated the concentrated stabilized solutions that are available to be diluted for use, and the so-called Dakin's tablets to be dissolved in a quantity of water. St. Luke's pharmacy has followed the

procedure of preparing Dakin's solution by the reaction of sodium carbonate on a solution of bleaching powder. This method requires skill and care, and from six to eight hours of processing.

Dakin's solution, regardless of the method of preparation, loses its efficiency after forty-eight hours, and on longer standing secondary products form which irritate the wound. Adding chemicals to stabilize the solution interferes with its reaction on micro-organisms.

### A Simple Reaction

It is a task for the pharmacist always to have available a fresh supply of high quality Dakin's solution. Recently a new type of electrolytic cell for the preparation of Dakin's solution was placed in St. Luke's Hospital. This cell produces a standard solution of pure, neutral hypochlorite, and contains none of the impurities that are found in chemically prepared hypochlorite. The apparatus is simple, automatic and foolproof. It is only necessary to supply a simple salt solution and turn an electric switch. Fresh, nascent hypochlorite is pro-

<sup>1</sup>Dakin's solution must not contain caustic alkali. The strength of the hypochlorite must be absolutely fixed between 0.45 and 0.5 per cent. Solutions that are weaker than 0.45 per cent are not effective; those that contain more than 0.5 per cent of hypochlorite are irritating to the tissues.

COLLABORATED DATA OF SEVEN-DAY ASSAY OF DAKIN'S SOLUTION PRODUCED BY THE  
ELECTROLYTIC CELL

<i>Data Assayed Prepared</i>	<i>No. of Cc. N/10 Sod. Thiosulphate</i>	<i>No. of Gm. NaOCl in 100 Cc. sol.</i>	<i>U. S. P. Rubric</i>
1-10-32	12.9	0.476681	Dakin's solution contains no less than 0.45 per cent and not more than 0.50 per cent of NaOCl equivalent to 0.43 to 0.48 per cent of available Cl <sub>2</sub> .
1-11-32	12.3	0.45450	
1-12-32	11.8	0.43603	
1-13-32	11.4	0.42325	
1-14-32	11.0	0.40654	
1-15-32	10.6	0.39169	
1-16-32	10.3	0.38060	
1-17-32	10.3	0.36950	

*Now Available*

# ARMOUR'S Concentrated Liver Extract with Iron

Concentrated Liver Extract with Iron (Armour) developed in line with the successful studies of eminent specialists in the field of pernicious and secondary anemia, is now available to the medical profession.

The value of liver in the treatment of true secondary anemia has been definitely established since 1920, and liver therapy is now considered a specific for correcting the blood deficiencies of pernicious anemia. It is also common knowledge today that iron is a necessary factor in the production of hemoglobin. The required amount of iron varies in the different forms of secondary anemias, and, to obtain positive effect, large doses must be given. Liver and iron medication has been well tolerated and of specific benefit in preventing or overcoming the involvement of the central nervous system in pernicious anemia.

The adult dose is one to two teaspoonfuls two or three times a day, depending on degree of anemia. If desired, a tablespoonful once or twice a day may be taken. It may be given straight or diluted with water, milk, orange juice, etc. The dose for infants is 1 to 2 drops, gradually increased to 5 to 10 drops, in a little sweetened water. Concentrated Liver Extract with Iron should be administered during or immediately after meals in order to produce the best results. Each teaspoonful contains 12 grains of iron ammonium citrate, equivalent to 128 milligrams of metallic iron.

Concentrated Liver Extract with Iron is recommended for use in secondary anemia and such cases of primary or pernicious anemia where large doses of iron are indicated. It is obtainable in 8 ounce bottles.

**ARMOUR and COMPANY**  
**CHICAGO**

*"Headquarters for medical supplies of animal origin"*

# NEW GARLAND

## HEAVY DUTY GAS RANGES FOR HOSPITALS

**SANITARY**—Smooth front, concealed manifold, hinges, and door springs. Enameled oven linings—clean instantly, won't rust.

**FAST**—All hot top, nine single jet burners form solid sheet of flame under entire top. Can also be furnished with open top for short order work, fry top, or griddle top.

**ECONOMICAL**—Perfect combustion, no fuel waste, heavy insulation, low fuel cost, cool kitchen. Oven heat control (optional) further cuts fuel cost.

The old Garland is used by 75 per cent of all large hospitals and similar institutions in this country. The New Garland is still better. Write for details.

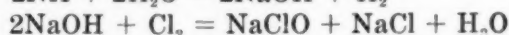
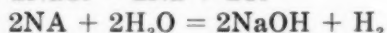
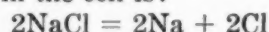
GARLAND DIVISION

DETROIT-MICHIGAN STOVE COMPANY

DETROIT, MICHIGAN



duced at the rate of 25 cc.'s a minute. The reaction in the cell is:



The problem of deterioration is eliminated. There is no occasion for keeping the solution on hand since it may be made as needed.

The cost of producing the solution by the electrolytic cell amounts to about four cents a gallon. When the solution is chemically prepared the cost is nominal, but a great amount of time and care is required.

### *Ample Quantity Is Produced*

The electrolytic cell in use at St. Luke's Hospital produces three gallons of Dakin's solution in eight hours. This is probably more than is necessary for the average sized hospital. A larger apparatus is obtainable producing from five to ten gallons hypochlorite a day. Following is one series of many tests made of the Dakin's solution produced by the electrolytic cell.

**Preparation:** Dakin's solution was prepared, using the electrolytic cell, 50 Gm. sodium chloride, 5 Gm. sodium bicarbonate, 2 liters distilled water yielding 2,000 cc. Dakin's solution.

**Description:** The solution has a faint sky blue tinge and has a slight odor suggesting chlorine (corresponding to U. S. P. description).

**Test for Purity:** 0.02 Gm. of powdered phenolphthalein added to 20 cc. Dakin's solution. No red color was produced on agitation (corresponding to U. S. P. test of maximum alkalinity). About 5 cc. phenolphthalein T. S. added to 5 cc. of Dakin's solution contained in a test tube, a momentary red flash was produced (corresponding to U. S. P. test for minimum alkalinity).

**Assay:** 10 cc. solution, diluted with 50 cc. distilled water, measured with pipette, 1 Gm. potassium iodide and 5 cc. acetic acid are added. The liberated iodine is titrated with tenth normal sodium thiosulphate (N. F. O. 992) using starch T. S. as indicator. Each cc. of tenth normal sodium thiosulphate corresponds to 0.003723 Gm. NaOCl.

### *Procedure Is Simple*

A fresh solution was prepared, titrated and preserved in a well stoppered bottle, placed in a cool place, protected from light (corresponding to U. S. P. directions). The same solution was assayed for seven consecutive days. The collaborated data are shown in the table on the preceding page.

With an electrolytic cell, of the special type referred to, it is no longer necessary to prepare Dakin's solution from ingredients which must first be submitted to complicated tests because of vari-



# PROOF

*of the equipment  
is in the using—*



When selecting any equipment for your hospital you are undoubtedly swamped with conflicting *opinions* about the merits of varicus equipment. But the real test is how it performs in actual service.

Hundreds of installations in the leading and most progressive hospitals throughout the country have proved the value and economy of Day's Cubicle Curtain Equipment under every possible condition—in wards, semi-private rooms, treatment rooms, dressing rooms, and for the many other uses where screening is required.

Day's Cubicle Curtain Equipment is an overhead system of curtain screening which provides complete privacy without the objectionable features found in less efficient and makeshift equipment. With Day's System any one bed may be totally enclosed with one curtain. All equipment is suspended from overhead so that the floor is always clear. When not in use the curtains are pushed out of the way against the wall, thereby allowing complete ventilation and a clear view of the entire room from any point.

With Day's Cubicle Curtain Equipment privacy is possible even with the most compact arrangements—and yet each bed is always and entirely accessible. It is the modern method of bedside screening that meets with the instant approval of doctors, nurses, patients and visitors.

We suggest that you see the practical advantages of Day's Cubicle Curtain Equipment in actual service—and shall be glad to send you the names of several installations in your vicinity.

**H. L. JUDD COMPANY, INC. • HOSPITAL DIVISION**  
87 CHAMBERS STREET      Founded 1817      NEW YORK, N. Y.

## DAY'S • CUBICLE • CURTAIN • EQUIPMENT

Send  
for your  
copy of  
this booklet



H. L. JUDD COMPANY, INC.  
87 Chambers Street, New York City

Please send me "Privacy in the Modern Hospital"—which explains how leading hospitals have solved the problem of suitable screening.

Your name .....

Hospital .....

Address .....



## Reinforced Rubber Stair Treads

**T**HEY will cut down maintenance and replacement costs . . . they are safe, comfortable, silent . . . and are practical for new or existing buildings. Stedman maintained quality is purchasable at 1932 prices to fit 1932 Budgets. Write us for more complete information and for our new color catalogue. Stedman Rubber Flooring Company, South Braintree, Mass.

**STEDMAN  
REINFORCED  
RUBBER TILE**

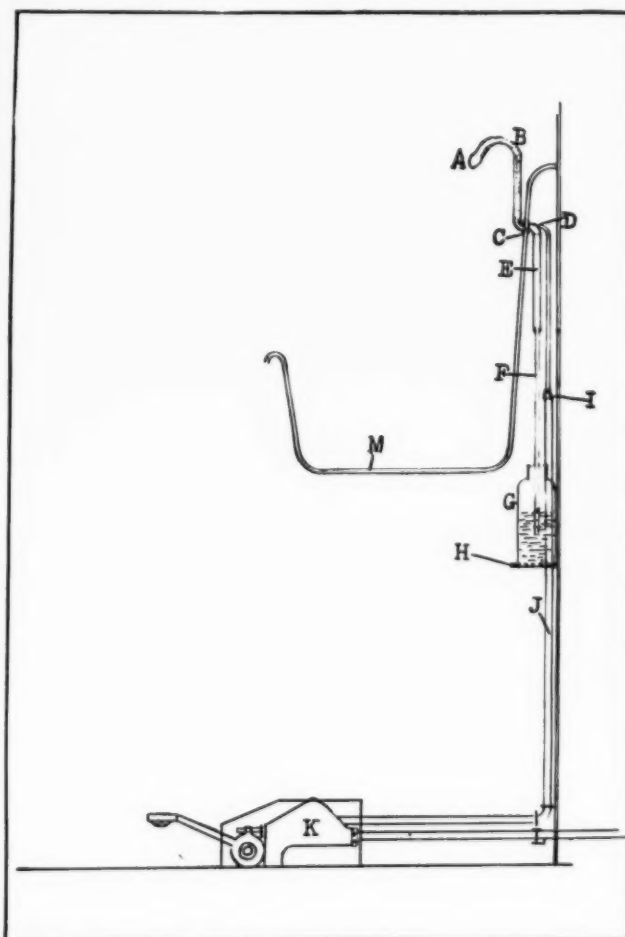
able chemical composition. The skill and care heretofore required and the delay and inconvenience heretofore involved in producing Dakin's solution are no longer necessary handicaps to its use. Any novice may produce the highest quality of Dakin's solution with the same assurance as an experienced laboratory technician.

## An Atomizing Alcohol Dispenser for the Scrub-Up Room

By E. P. MAGEE

Chief Engineer, Touro Infirmary, New Orleans

A difficulty commonly experienced by hospitals is the efficient and economical dispensing of alcohol in the scrub-up rooms of a surgical operating de-



A—1/8 C.P. pipe goose neck; B—3/16 O.D. copper tubing 3 inches from end of goose neck; C—1/8 C.P. pipe flange; D—1/8 brass ell drilled to receive copper tubing; E—1/8 by 6-inch brass nipple into ell; F—3/16 O.D. tubing soldered to 1/8 by 6-inch nipple; G—alcohol container; H—bracket for container; I—1/8 by 1/4 reducer from 3/16 tubing to air line; J—1/4 C.P. pipe from foot valve; K—foot pedal valve; L—1/4 C.P. pipe to air compressor; M—scrub sink.

partment. Many are the methods in use, from the simple pan of alcohol or the improvised rubber tube pinch flow to the spray adapted soap dispenser type of pump.

During a recent rehabilitation of the main oper-



Imagine the thrill with which Mlle. le Gras received the Queen's messenger that day in 1654. For over twenty years she and her little group of "servants of the poor" had been struggling against misunderstanding, petty jealousy and indifference with only the supreme faith and patience of Vincent de Paul to sustain them.

Now, at last, by requesting nurses for Sedan, the Queen, herself, had put her seal of approval on the work. As "Sisters of Charity" they have served ever since in peace and war . . . For "remarkable bravery in action" they have won the coveted cross of the Legion of Honour. Unnamed crosses without number they have deserved for thousands of deeds no less brave but only less dramatic.

WILL ROSS, INC., WHOLESALE HOSPITAL SUPPLIES  
779-783 N. Water Street Milwaukee, Wisconsin



Refrigeration at the Harborview Hospital, Seattle, is supplied with Frick CO<sub>2</sub> Equipment.

## They All Use



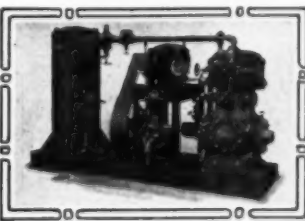
## Refrigeration



The refrigerating load at the De Paul Hospital in St. Louis is adequately cared for by Frick Refrigeration.



Medical Refrigerator with Multi-temperature Control and Ice Making Pans at Shanghai.



The New Frick Type HA Combined Refrigerating Machine.

Over a hundred fine hospitals, some of them in distant countries, are counted among the thousands of users of Frick Refrigeration. As builders of both ammonia and carbon dioxide equipment, with experience dating back to 1882, we can meet your requirements with full satisfaction, regardless of the size of your institution.

Branches and distributors in 85 cities. Write for bulletin and estimate now.

**Frick Company**  
WAYNESBORO, PA., U.S.A.  
ICE MACHINERY SUPERIOR SINCE 1882



**Comfort  
Convenience  
Service**



# COLSON WHEEL CHAIRS

Built to give your patients the utmost in comfortable, economical service, Colson Wheel Chairs offer the variety of styles to meet every condition of weight, size or special disability in the patient. Anti-tipping devices for safety—cushion tires and ball bearings assure comfort and complete rubber bumpers prevent damage. All adjustments easily and simply operated.



If you do not have the Catalog of the complete Colson Line—casters, wheel stretchers, trucks for every purpose, laundry equipment, etc., in your file, we will gladly send it to you.

THE COLSON CO.  
ELYRIA, OHIO

**Colson**

**HOSPITAL EQUIPMENT**  
SURGICAL, FOOD SERVICE, FURNITURE

ating suite at Touro Infirmary, New Orleans, connections were made in all scrub-up rooms with the central air compressor which supplies each operating room. The problems to be solved were: (1) an efficient atomizing bulb; (2) foot valve control; (3) alcohol storage and pickup.

It was not found possible to purchase an atomizer bulb of a size suitable for the purpose. As a result, it was necessary to devise one. How this was done is shown by the accompanying sketch. An air pressure of 30 pounds is adequate and delivers a fine spray of 70 per cent alcohol to the hands and arms. The air compressor must be of sufficient capacity to deliver 1 cubic foot per minute for each outlet and a standard unit foot valve was found to be satisfactory to control the air flow. A pickup of 24 inches was the maximum suction obtained and the alcohol storage was, therefore, provided on a bracket immediately beneath the scrub sink. Jars commonly used for canning purposes are utilized as alcohol containers and rest on brackets which, when swung aside, permit the jar to be lowered and refilled. A flat rubber slip cap covers the mouth of the jar to minimize the loss from evaporation.

The convenience and cleanliness of this method are obvious but economy is an added factor and makes unnecessary any attempt to reclaim used alcohol.

## A Continuous Bath and How It Functions

A continuous bath was recently installed in Grant Hospital, Chicago, through the efforts of the woman's auxiliary of the hospital. The bath will be used mainly for dermatologic, surgical, gynecologic, neurologic and medical cases.

The bathtub is 86 inches long, 39 inches wide and 25 inches deep. It is constructed as follows:

The inside of the bathtub is lined with stainless steel. Next comes a layer of wood veneer three-quarters of an inch thick. Then comes a layer of cork of the same thickness. This is followed by an air space of three-quarters of an inch. There is another layer of cork and of veneer, and the whole tub is covered with a plastic material.

The intake water is let in by means of two faucets at the head end of the tub. The overflow is regulated at the foot end. The regulating valve is so arranged that the tub can never overflow. When the water gets to a certain height it automatically flows out of the tub. With the intake at one end and the outlet at the opposite end of the tub there is a continuous flow of water through the tub. The mixing valve is so arranged that the temperature of the water may be controlled at all times.

The waste pipe is so constructed that either a

## Zip! And the problem is solved— KLOZTITE takes sanitary care of the patient's clothes

● Hundreds of hospitals have found Stanley's Patients Clothes Container to be the modern, low-cost, space-saving, sanitary way of taking care of the patient's clothes.

● In a compact space, 54"x18"x8", clothes are neatly hung on regular hangers suspended inside, with lots of room for hats, shoes, etc., on the bottom frame. When "zipped" closed, KLOZTITE is dustproof.

● Top and bottom frames are removable, so container can be laundered or sterilized. Made of heavy-duty, brown material. Identification tab attached.

SENT ON APPROVAL  
—price on request.

**Stanley**  
for  
Professional  
Standards



Stanley Supply Co.  
Hospital Supplies and  
Equipment  
118 E. 25th St.  
New York

## "RAPID TRANSIT"

Model FV-4  
Equipped with bulk  
containers and tray  
racks. All bulk or  
all tray service op-  
tional.



## FOOD-VEYOR *puts tray service on fast time*

Equipped with both hot and cold compartments, bulk containers and tray racks, "Maforco" Food-Veyor is a complete rolling unit for rapid, economical service to ward kitchens and rooms. Preserves proper temperatures and food flavors. Saves time, labor and confusion.

Write for Bulletin 32F for complete specifications.  
Also manufacturers of all types of hospital trucks.

**MARKET FORGE COMPANY**  
EVERETT, MASS.

BRANCHES IN PRINCIPAL CITIES

## HORNER BLANKETS

are the "Best Value" for you

regardless of the size  
of your supply budget

## HORNER BROTHERS

## WOOLEN MILLS

EATON RAPIDS, MICHIGAN

FOUNDED 1836

*Blanket Manufacturers for  
almost a century*

SAMPLES GLADLY SENT WITHOUT OBLIGATION

## Eminent Surgeons say Operay—



In the long list of Operay Multibeam equipped institutions there are surgeons who are unquestioned leaders in modern surgical thought and practice.

All these prefer Operay for the light they work under—it is pure white, practically shadowless and has the great virtue of entire maneuverability. For deep cavity illumination particularly.

*Ask for the list and  
complete details.*

OPERAY LABORATORIES, INC.  
Madison, Wisc.

Now an associate of the Scanlan Morris Co.  
Madison, Wisc.

## OPERAY MULTIBEAM

"Flexible as a Flashlight"

SEVEN SERVICES WITH ONE MACHINE

## New "HUSHED" HILD

Electrically Operated

### FLOOR MACHINE

Scrubs . . . Waxes . . . Polishes

An amazingly quiet-running electrically operated floor machine . . . designed specially for hospitals and similar institutions. Ingeniously constructed gear reduction unit is securely attached directly to motor. Banishes noise almost completely.

Easy to operate! The Hild is "self-propelling"—it creeps over the floor in any direction. Just guide it! 5 times as fast as other machines. Will easily repolish 5,000 sq. ft. of waxed floors in an hour! Efficient—because entire weight is on brush.

**HILD Guaranteed Floor Treatments for all types of floors for all traffic conditions**

Hild "No. 1 Special"—varnish-wax treatment for wood, linoleum, cork, concrete, etc.

Hild "No. 2 Special"—varnish-wax treatment for rubber floors.

Hild "No. 3 Special"—self-polishing treatment for all types of floors.

Hild Paste Wax.

Hild Floor Seal.

Hild Liquid Floor Cleaner

Hild Floor Bleach

Hild Varnish Remover

5 Day Free Trial! Write for Details



for scrubbing  
for waxing  
for scraping  
for grinding  
for polishing

Hild Floor Machine Co., 110 W. Lake St., Chicago

## THORNER SILVER



THORNER SILVER fulfills the most exacting demands because it is specially designed for Hospital service. The perfect shape of every piece facilitates cleanliness, the extra heavy plating insures long life, and the fine design insures attractiveness.

*Samples Cheerfully Submitted*

**THORNER BROTHERS**  
135 FIFTH AVENUE NEW YORK

**Costs Less Per Year of Service**

small or a large quantity of water can be continuously let out of the tub, which is advantageous when the tub is to be cleaned or an immediate amount of fresh water is desired. There is one pipe within another with numerous small holes, which does the regulating.

The hammock upon which the patient is placed has an iron framework which is galvanized. A wire



mesh is stretched over this framework so that the water may come through it readily. The hammock has an adjustable foot and head rest. It may be lowered to the bottom of the tub or held at any desired depth in the tub. Two worm gear winches arranged on a line shaft with cables running over pulleys operate the hammock. Two cables are fas-



tened at each end of the hammock and run at a slight angle to the ceiling to prevent as much as possible the sway of the hammock. These cables are fastened to the hammock with bronze snap hooks so that they may be taken off easily.

Rubber bumpers on all corners of the hammock prevent scratching. Two connecting pieces of wood underneath the hammock fold lengthwise when the hammock is submersed. When the hammock is raised either to place a patient upon it or to remove



## Shock Absorbing CASTERS

*for Wards, too?*

**Of course!** Why deny any of your patients the comfort of Shock Absorbing Casters?

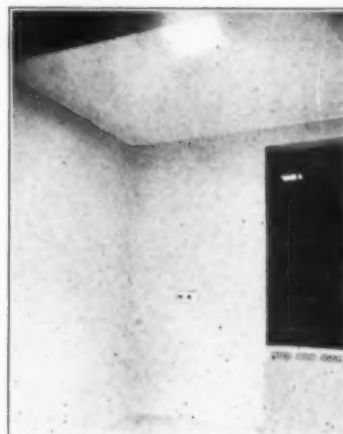
Yes, they are better casters but they cost so little more than the ordinary kind, they last so much longer and prolong the life of equipment . . . it's wise economy to invest in them for all your rolling equipment.

Let us send you a trial set, on approval. See for yourself how superior they are. Write for them today.

### JARVIS & JARVIS, INC.

102 So. Main St. Representatives in all Principal Cities Palmer, Mass.

Single room lighted with Holophane Specific A-755 in Grasslands Hospital, Valhalla, New York.



To promote the SAFETY and COMFORT of PSYCHIATRIC Patients . . . . .

Holophane provides this special unit to be installed flush in the ceiling, protected by shatterproof cover glass. It furnishes uniform, comfortable illumination, with a secondary illumination which is low enough not to disturb a sleeping patient, yet high enough for night inspection by nurses and internes. For engineering service on any phase of hospital lighting, address Holophane Co., Inc., 342 Madison Ave., New York.

## H O L O P H A N E



### PLANNED LIGHTING

*produces the greatest amount of useful light from Mazda lamps*

## "UNNA'S" PASTE KNOWN UNDER OUR FORMULA AS "VARTEX"



Vartex cannot be detected through the finest sheer hose, as you will note in the above picture.

. . . Your Hospital cannot afford to produce Unna's Paste. A better compound at less expense is available in our

### "VARTEX"

. . . We can supply you Unna's Paste fresh at all times in air tight containers under our formula known as "VARTEX" cheaper than you can make it. Ask us for prices and sample.

### THE VARTEX COMPANY

2630 East 75th Street, Chicago, Ill.

NOTE: Book of technique of application of Unna's Paste sent free with each hospital order.

*A Quality*  
**Not Indicated  
by its Present**

## LOW PRICE



This Model B Electric Fruit Juice Extractor is made for efficient performance—materials and workmanship the best that can be put into a product. The extractor cone and bowl are porcelain china—white inside and a beautiful shade of green outside to match the base. Height 10 inches; diameter 7 inches. List price \$12.85. It is easy to operate and easy to clean. Operates on either alternating or direct current, 110 volts. Ask your supply jobber now about this extractor.

SIGNAL ELECTRIC MFG. CO.

Menominee, Michigan

## SIGNAL

## RALKS' HOSPITAL UNIT



### FIREPROOF

Bears the seal of approval of the Underwriter's Laboratories for use in hazardous location. No exposed spark gap at any time, thus eliminating the danger of fire or explosion due to the machine.

### ADJUSTABLE VACUUM BOTTLE HOLDER

By pressing a simple lever, the bottle is released and can be emptied quickly. Any inexpensive 32-oz. bottle or ANY SMALLER SIZE BOTTLE may be substituted instantly, held firmly and give perfect suction.

### DOUBLE HEATING DEVICE

Electrically heats water around ether bottle and then heats the ether vapor so that patient receives warm ether vapor.

### FILTER SYSTEM

Purifies the ether at every stage and prevents any particles from reaching the patient.

### TWO ROTARY COMPRESSORS

directly connected to motor, *instead* of blower units or cylinders with pistons and valves, assures smooth, quiet operation and minimizes attention or repairs.

*Send the coupon for illustrated folder giving full details.*

Sold by leading hospital supply houses

J. SKLAR MFG. CO., 133 Floyd St., Brook'lyn, N. Y.  
Please send illustrated folder of your

RALKS' HOSPITAL UNIT

Hospital.....

Address.....

Attention of.....

MH 7-32

him, these wooden pieces are turned out and placed on top of the sides of the tub to take the weight of the hammock and make it rigid. When the hammock is in this position it has the same elevation as most carts. This is convenient in handling patients.

A table which may be tilted in any direction and raised or lowered as desired is fastened to the side of the tub so that a patient may partake of his meals while in the tub. This table may also be used as a support for books and magazines which the patient may read while he is in the bath.

Bathtubs of this type are in common use at the European medical centers, especially in Vienna, but have not been employed to a great extent in this country. About 1890, Doctor Hebra, a dermatologist of Vienna, opened a station for continuous baths in the *Allgemeine Krankenhaus* of his city. In 1917, the original station which Doctor Hebra built was replaced by one equipped with twenty-two continuous baths.

Doctor Hebra and other physicians have found that in many cases patients can be kept in a continuous bath for many weeks and in some cases even months to the advantage of the patient.

The continuous bath is used with good results in such dermatologic cases as pemphigus, extensive severe burns, erysipelas, acute weeping eczema, decubitus or bedsore, ulcers produced by roentgen rays and many other skin diseases.

The continuous bath is also advantageous in surgical cases, such as osteomyelitis, infected wounds, frozen extremities and other diseases.

Many neurologic diseases, such as spondylitis, tabes, myelitis and sclerosis, are treated to good advantage with a continuous bath.

## A Rubber Tire That Stands Hard Usage

A new type of rubber tire for truck wheels and casters is now being made. The tire has a hard rubber base impregnated with cord fabric similar to that used in the casing of an automobile tire. It is said that this type of wheel rolls as easily as other types of wheels and will last much longer than the ordinary rubber tire.

## A Direct or Indirect Light Unit for Hospital Rooms

A wall light fixture fitted with two lamps and reflectors, designed for the hospital room, makes possible a selection of either direct or indirect lighting or a combination of both.

The general lighting of the room is provided by the upper reflector which produces the indirect



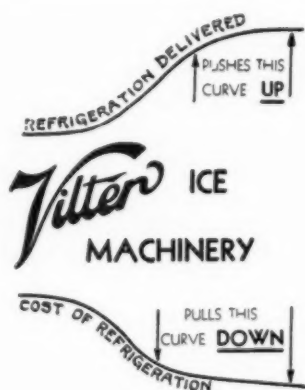
## Attractive Rooms for Nurses' Homes



The picture illustrates a very attractive group. It is the most popular one in our entire line. The reasonable cost may be one of the reasons for this popularity.

Write for full information

**HARD** MANUFACTURING CO.  
134 Tonawanda Street  
Buffalo, N. Y.



## These Curves Are Very Important

It is surprising the economies which sometimes can be effected with modern applications of ice machinery.

We have many customers who rely on us to keep them constantly informed as to new things in refrigeration. It's a good plan, easily worth a try-out. The Vilter Representative has access to records and information which is based on the unshakeable authority of actual practice. He has a list of standard equipment supplemented by special designs for the correct solution of any ice machinery problem.

Why not call us in and get our recommendations. There is no obligation incurred in doing so, or if you just want some literature on compressors, condensers, ammonia fittings or other ice machinery, we will forward it and no salesman will call if you do not wish one to.

**The Vilter Mfg. Co.**

Est. 1867

2123 S. First St., MILWAUKEE, WIS.



Over two thousand  
hospitals use  
our forms

### Superintendents

should have our

**CATALOGS  
and FREE  
SPECIMENS**

of

**Charts and Records**

**AMERICAN COLLEGE OF SURGEONS**  
(Standardized Records)

**CATALOG No. 10 (100 Miscellaneous Forms)**

**TUBERCULOSIS RECORDS**

**OCCUPATIONAL THERAPY RECORDS**

**VALUABLE RECORD BOOKS**

**HOSPITAL STANDARD PUBLISHING COMPANY**

40-42 S. PACA STREET • BALTIMORE, MD.

Write for samples : : Sent on request

## The REGAL



**BED PAN WASHER  
and STERILIZER**

*Built-in Type*

**LAST WORD  
IN RECESSED  
EQUIPMENT**

It really washes; it really sterilizes. The slightly higher price is justified by its mechanical excellence and astounding efficiency. Rack (patent) delivers both water and steam through 3 nozzles inside the pan. As completely automatic as can humanly be devised. Made also in free standing Pedestal and Hopper Type.

WILMOT CASTLE CO., 1153 University Ave., ROCHESTER, N. Y.

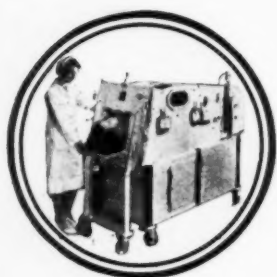
# CASTLE

Write today for data on the Regal.

Name.....

Address.....





## a new reprint on "polio"

By DR. JAMES WILSON of the  
CHILDREN'S HOSPITAL, BOSTON

For the first time, this valuable information entitled "The Treatment of Bulbar and High Spinal Types" is available in printed form. It shows some of the most recent advances in the treatment of this disease and all hospitals who admit infantile paralysis cases will find this latest reprint of the greatest value.

Write for  
Reprint M

## The DRINKER RESPIRATOR

Manufactured and sold only by

WARREN E. COLLINS, INC.  
555 HUNTINGTON AVENUE, BOSTON, MASS.



## 2 NEW SOAPS From an Old Soapmaker

For 103 years the Puritan Soap Company has specialized in high-grade special-formula soaps. These two new soaps have been adopted by some of the world's largest Hospitals:

**PINEZO**—Potash base, neutral, cleans very rapidly, prevents deterioration of flooring, imparts bright, enduring sparkle, and removes "medical" odors from corridors and waiting rooms.

**SURGICAL GREEN**—A neutral, clear amber jelly, dissolved in water for surgical scrub-up for lavatory dispensers, washing walls, woollens, woodwork, etc.

Write for free samples.



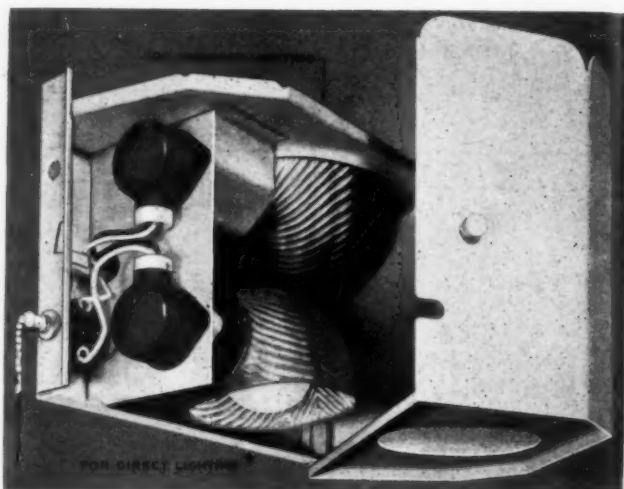
# PURITAN

SOAP COMPANY

Rochester, New York

lighting often desirable in hospital rooms. The lower reflector provides direct lighting for reading and observation. The combination of the direct and indirect lighting provides a diffused yet intense light for inspection and dressing by the surgeon and the nurse.

The indirect reflector is for use with 60 to 150-watt lamps, and is provided with a dust cover. The direct reflector is for use with 25 to 60-watt



lamps, and has a diffusing glass screen to soften the quality of the light.

One switch is included to control the direct light. If the room does not have a wall switch, a standard pull switch can be installed to control the indirect light at the fixture. The complete unit is furnished in a zinc plate ready to be painted the same color as the walls of the room. The surfaces are all flat so that any stencil or transfer decoration can be added to harmonize with the decoration of the room. This light is installed over the outlet box, and is attached to the wall by means of wood screws or toggle bolts. In new buildings, the height from floor to center of outlet box should be 78 inches.

## A Revolving Bed Bumper That Protects the Walls

The necessity for shifting furniture and moving beds in the hospital is likely to damage the walls to such an extent that frequent redecoration is required. As a preventive, a caster that has a revolving horizontal wheel of rubber composition above the caster wheel is now being made. The horizontal wheel acts as a bumper as well as a roller. A nonrusting ferrule carries the bumper wheel, and a seamless brass bearing makes operation quiet and handling easy. The easy turning of the horizontal wheel as it revolves across the wall prevents smudging.